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Pepperdine University
Graduate School of Education and Psychology

DEVELOPMENT & EVALUATION OF AN INTRODUCTORY WEBINAR TRAINING FOR
MENTAL HEALTH PROFESSIONALS WORKING WITH FAMILIES OF SEXUALLY
ABUSED CHILDREN: A STRENGTHS-BASED SOCIOCULTURAL APPROACH

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Heidi Michelle Alexandria Arredondo

July, 2019

Shelly P. Harrell, Ph.D. - Dissertation Chairperson

This clinical dissertation, written by

Heidi M. A. Arredondo

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

To my parents, who have provided unwavering support and unconditional love throughout my life. Your strength, sacrifice, and perseverance provided me with opportunities I am forever grateful for. The importance of family togetherness and resilience woven into your life stories helped inspire this dissertation.

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- Arredondo, H., Lares, S., & Walker, A. (November 2015). Doctoral Roundtable: A Presentation for Student Clinicians. Pepperdine University; Irvine, CA.

ABSTRACT

The purpose of the current project was to develop a webinar to support the training of mental health professionals to work competently with the widespread phenomenon of childhood sexual abuse. A review of the literature suggests that the scope of CSA is broad, however, there is much more to be known about the unique challenges families face as they support their affected child. Survey results gathered as part of this project revealed several trends: MHPs do not receive specialized training in CSA matters, MHPs feel unprepared for working with families of sexually abused children (FSAC), and various sociocultural factors potentially relevant to treating FSAC were identified. This project focused specifically on the needs of families of sexually abused children by creating an introductory webinar training for mental health professionals that presents information relevant to working with families of sexually abused children, with particular attention to sociocultural and strengths-based perspectives. After an introductory webinar was developed, evaluation of the webinar training content revealed that it is best suited for early-career MHPs. Evaluation of the webinar training further indicated it was informative, focused, specialized for FSAC, and beneficial. While several limitations have been identified, the study has broadened the scope of current training by emphasizing the importance of family systems, sociocultural, and strengths-based approaches in the treatment of child sexual abuse. Creating an introductory webinar resource for training MHPs working with FSAC is a preliminary step towards increasing the educational resources available online for this underserved population.

Chapter 1: Introduction to Child Sexual Abuse

The sexual abuse of children is an all-too-common occurrence across the globe that transcends race, socioeconomic status, and cultural background (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Sanjeevi, Houlihan, Bergstrom, Langley, & Judkins, 2018). Despite the high prevalence rates of child sexual abuse (CSA) and its association with sexual re-victimization in adulthood (Classen, Palesh, & Aggarwal, 2005; Hillberg, Hamilton-Giachritsis, & Dixon, 2011) as well as a range of mental health difficulties and behavioral problems, the mental health field continues to face challenges in meeting the needs of these populations (Kenny & Abreu, 2015; Perez-Fuentes et al., 2013).

Although professional activities vary widely amongst mental health professionals (MHPs) including counselors, psychologists and social workers, these individuals share a unique position in society with regard to matters of child sexual abuse. Mental health professionals, as mandated reporters, are involved in gathering, documenting, and managing sensitive client information. Moreover, professional activities and clinical duties include gathering of psychosocial histories as well as obtaining information related to current functioning and symptomology. Oftentimes, childhood histories of emotional, physical, sexual abuse, or neglect (and the subsequent development of psychological and behavioral problems) are at the root of many clients' presenting problems (Peterson & Urquiza, 1993). Kenny and Abreu (2015) indicate that sexual abuse victims account for more than half of all individuals in the United States who receive mental health counseling and the relationship between child sexual abuse and utilization of mental health services is well established (Read, McGregor, Coggan, & Thomas, 2006; Sanjeevi et al., 2018). Further, it is common for mental health professionals to encounter clients with either a childhood history of abuse or neglect, or a suspicion of or actual evidence of

current abuse (Kenny & Abreu, 2015; Peterson & Urquiza, 1993). Thus, mental health professionals are involved in the detection of abuse, treatment of children and adults with sexual victimization histories, and are placed in direct contact with perpetrators and families of sexually abused children (Kenny & Abreu, 2015). Additionally, mental health professionals are oftentimes the first to come into contact with a victim or a family member and the responsibilities of a mental health professional mirror those of first responders; they play a vital role in diminishing acute distress and potential safety risks of involved parties (Kenny & Abreu, 2015; Kitzrow, 2002; Read et al., 2006).

Mental health professionals are critically influential in decreasing the immediate, acute effects of child sexual abuse; they are involved in conducting proper assessment of trauma histories, informing best course of treatment, directing access to resources, and they can also influence public policy and research (Kenny & Abreu, 2015). Although one may expect that mental health professionals are well trained in obtaining thorough trauma histories, responding to abuse disclosures, and conceptualizing cases with histories of sexual victimization, literature suggests that there is a strong need for mental health professionals to obtain specialized training in child sexual abuse matters (Kitzrow, 2002; Read et al., 2006). Commentary from research on CSA topics asserts that this need for more specialized CSA training exists due to few mental health professionals' exposure to any training in child sexual abuse during their formal education (Kitzrow, 2002). Read and colleagues (2006) suggest that trainees in the field of mental health possess their own personal barriers to asking about abuse; these include: concerns about upsetting clients, vicarious traumatization, inappropriate fears of inducing 'false memories,' inaccurate assumptions about some diagnoses (e.g., psychosis) being unrelated to abuse, rigid adherence to a bio-genetic paradigm, and assumptions that CSA is less relevant to males and

older people. Literature suggests that mental health professionals increase their individual knowledge base, including knowing the definitions, dynamics, and effects of child sexual abuse; strengthen their clinical skills in assessment; increase awareness and understanding of how contextual (environmental) and developmental factors affect the experience of child sexual abuse; obtain specialized training to provide effective clinical intervention for children and their families; and receive ongoing education that is unique to child sexual abuse phenomena (Kenny & Abreu, 2015; Peterson & Urquiza, 1993; Read et al., 2006). By incorporating more formal training of child sexual abuse, mental health professionals' curricular and clinical development will be enhanced, and earlier exposure and training can potentially help break the silence of CSA. Due to the widespread prevalence of child sexual abuse, the profound impact on mental health, the complexity of treatment issues, and ethical considerations that may arise when mental health professionals are not adequately trained to treat these issues, providing specialized training is critical. Kitzrow (2002) suggests that serious ethical issues may arise when mental health professionals are lacking in adequate CSA training and that mental health professionals with training deficits may cause harm by practicing outside the boundaries of their competence.

The need for proper mental health professionals' training is supported by the long list of negative consequences associated with CSA. There is also strong research support indicating that child sexual abuse is a significant risk factor for a variety of psychological difficulties and behavioral issues (Classen et al., 2005; Hillberg et al., 2011; Lalor & McElvaney, 2010). This suggests that although people may not seek specialized services for child sexual abuse, individuals, families, and perpetrators may present in therapy with symptoms, disorders, and dysfunction that is related to ongoing, previous or suspected child abuse. Thus, the likelihood of mental health professionals having to deal with issues pertaining to child sexual abuse is high. In

addition to the various psychological, emotional, cognitive, social, and behavioral problems associated with sexual victimization, there are substantial and increasing economic costs attributed to CSA victims. Letourneau, Brown, Fang, Hassan and Mercy (2018) estimate the average lifetime cost of each nonfatal female victim of child sexual abuse to be upwards of \$280,000; the study reported having insufficient information to provide an estimated average lifetime costs of nonfatal male victims of child sexual abuse. Therefore, the treatment for all child abuse, including CSA, can potentially cost more than other significant health conditions, including stroke and type 2 diabetes (Fang, Brown, Florence, & Mercy, 2012). The need for properly addressing CSA needs can thus be considered a public health concern.

Additionally, media sources continue to provide coverage of sexual crimes against children, supporting the claim that it garners significant public attention both in with the domestic and international arena. Despite the news coverage and social concern for the welfare of children, difficulties establishing accurate prevalence rates and definitions of child sexual abuse persist.

Prevalence Rates

Accuracy of child sexual abuse prevalence rates continuously remains in question, as estimates vary enormously; 2% to 62% depending on the definition and sampling method used (Hunter, 2006). Stoltenborgh, Van Ijzendoorn, Euser, and Bakermans-Kranenburg (2011) suggest an estimated average worldwide prevalence of child sexual abuse to be 11.8%. Three meta-analyses published within the last decade, which examined studies published between 1982 and 2009, suggest that global prevalence rates of CSA range between 7.6% and 8.0% among males and 15.0% and 19.7% among females (Sanjeevi et al., 2018). Other journal articles indicate a national prevalence rate of 10.14%, with 24.8% found in men and 75.2% in women,

whilst other studies indicate that 16% of men and 25% to 27% of women report the experience of childhood sexual violence (Sumner et al., 2015). The variation in prevalence rates largely depends on the definition of sexual abuse being used, population sampled, data collection methods, response rates, as well as other methodological and cultural factors (Haugaard & Emery, 1989; Hunter, 2006; Sanjeevi et al., 2018). Due to the lack of consistency and cohesive information regarding CSA prevalence rates and definitions, there are likely varied perceptions of the scope of the problem as well as a variety of approaches to clinical assessment and treatment.

Disclosure of Child Sexual Abuse

One of the many critical components necessary to thoroughly understand the complexity of child sexual abuse is the nature of reporting and disclosure. Somer and Szwarcberg (2001) indicate four variables affecting disclosure: psychological variables (e.g., distortion of oppression, guilt, self-blame, helplessness, emotional attachment); family variables (e.g., loyalty, obedience, integrity); social variables (rejection from others, mistrust of judicial system, publicity); and trauma-related variables (e.g. intensity of traumatization). With regard to who receives disclosures, mothers and peers were the most common recipients of disclosure (Malloy, Brubacher, & Lamb, 2011; Somer & Szwarcberg, 2001), with 15.1% of cases being reported to authorities (Easton, 2013) and an even more miniscule number (8.3%) of individuals talking to professionals about the abuse (Pribe & Svedin, 2008). Factors that may influence the variance in disclosures are many: shame; stigma; relationship to perpetrator; not being believed by others; and safety concerns (Collin-Vezina, De La Sablonniere-Griffin, Palmer, & Milne, 2015). Delayed disclosures are common among males and females who have been sexually abused (Easton, 2013). Studies attempt to understand disclosure patterns, including the apparent gender

differences in rates of both early and delayed disclosure. Easton (2013) discusses 46% of males (compared to 71% of females) disclosed their abuse, suggesting that male survivors delay disclosure well into adulthood. Hunter (2006) adds that men are reluctant to disclose sexual abuse due to fears of being labeled as homosexual or deviant, which may partially explain the considerably underreported instances of sexual abuse for men. In addition to gender, some studies have shown that age may be correlated to disclosure of abuse (Sjöberg & Lindblad, 2002). More specifically Sjöberg & Lindblad (2002) assert that young age at time of first abuse experience tends to correlate with non-disclosure, longer delays in disclosure, and non-intentional disclosure. Gender and age differences in disclosure rates illuminate the nuanced complexities and varying responses to disclosures of child sexual abuse. Due to these and additional internal and external factors influencing disclosure, as well as the fact that many child sexual abuse incidents are never disclosed (McElvaney, 2013; O'Donohue & Geer, 2009), it can be said that the prevalence rates of child sexual abuse are largely under-represented. Given the interwoven and complex nature of mitigating factors related to child sexual abuse disclosure, it remains imperative that mental health professionals obtain the proper training and demonstrate a high level nuanced knowledge and cultural understanding of the phenomena in order to reduce the sequelae associated with disclosure of child sexual victimization.

Definitions of Child Sexual Abuse

In addition to the variance of disclosure rates, some of the variability in reported prevalence rates may be due to the lack of a consistent definition of child sexual abuse. Definitions vary based on the inconsistent criteria of whether physical contact is required, maximum age of the victim, minimum age of the perpetrator, minimum age difference between the victim and perpetrator, and whether only unwanted experiences are considered (Haugaard &

Emery, 1989). In a quantitative review of studies on childhood sexual abuse, researchers found that definitions that are restricted to intercourse produce lower rates than those that include other forms of sexual assault (Hamby & Koss, 2003). Research has also introduced the notion of cultural differences of child sexual abuse definitions, adding to the complexity of defining, disclosing, reporting, and adequately capturing the phenomenon of childhood sexual abuse in the United States. Whilst no significant differences have been found defining child sexual abuse amongst white Americans, African Americans, and Hispanic Americans (Lowe Jr., Pavkov, Casanova, & Wetchler, 2005), it is a noteworthy consideration to understand the lack of a singular definition of child sexual abuse that is consistent across cultures. From an empirical perspective, the need for producing a common definition of CSA is great. However, cultural notions of what constitutes abusive behavior may vary, making it difficult to arrive at a singular definition of child sexual abuse that is consistent across cultures. Given that the literature also points to the notion that children are more likely to be victimized by someone they know rather than a stranger and that family violence or safety risks prevent disclosure of abuse (Tapia, 2014), it is important to understand how sexual abuse can affect the child's larger social context; parents, siblings, community members, teachers, and even individuals who may know both the child and perpetrator may experience some degree of distress (Alaggia & Kirshenbaum, 2005; Somer & Scwarcberg, 2001). Thus, child abuse is a widespread phenomenon in which multiple parties are affected and require understanding, personalized support, and targeted therapeutic interventions.

Since The Child Abuse Prevention and Treatment Act was signed into law in 1974, there has been a notable mobilization of social services, mental health, educational, and legal systems to address the challenges in prevention and treatment of child sexual abuse matters (Peterson &

Urquiza, 1993). Despite the catalyst of the passing of the 1974 act, it appears that the majority of efforts have focused on prevention rather than treatment or training efforts (Finkelhor, 2009). Still, literature that addresses the complex issues related to CSA continue to support continued preventative efforts, and make little to no mention of training efforts for mental health professionals (Collin-Vézina, Daigneault, & Hébert, 2013). Although prevention programs have been increasingly more effective since the 1980's surge (Topping & Barron, 2009), what may come as a result of a focus on prevention rather than training or treatment is the inadvertent negligence, lack of resources, and treatment models that may be insufficient to those who have been victimized (O'Donohue & Geer, 2009). As a result, victims who come into contact with mental health professionals may find that providers are lacking in knowledge, training and resources for handling CSA related matters (Kenny & Abreu, 2015; O'Donohue & Geer, 2009; Peterson & Urquiza, 1993). Overall, the lack of convergent CSA data raises the need for greater specificity and understanding for how CSA is understood, defined, and studied. In turn, the evolution of CSA definitions also effect how mental health professionals understand, prepare, and treat CSA related matters.

Types of Child Sexual Abuse

The World Health Organization (WHO) states:

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; and the exploitative use of children in pornographic performance and materials. (World Health Organization, n.d.)

Child sexual abuse does not need to include physical contact between a perpetrator and a child. Some forms of child sexual abuse include: obscene phone calls, text messages, or digital interaction; fondling; exhibitionism, or exposing oneself to a minor; masturbation in the presence of a minor or forcing the minor to masturbate; intercourse; sex of any kind with a minor, including vaginal, oral, or anal; producing, owning, or sharing pornographic images or movies of children; sex trafficking; and any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare. Child sexual abuse may inadvertently warrant restrictive definitions as each term (i.e. “child”, “sexual,” and “abuse”) individually, has specific demand characteristics embedded into the definition. For example, as Tromovitch and Rind (2008) illustrate, the term “child,” which by definition is a prepubescent person, may imply that in most cases of CSA, the victim is under 12 years of age, where in reality many studies include the experiences of 15-, 16- and 17-year-olds. Moreover, the term sexual may take on a rigid definition of physical contact within the definition, though many studies include non-contact experiences under the umbrella of CSA, including voyeurism, exposure, and child pornography (Tromovitch & Rind, 2008; Peterson & Urquiza, 1993). Atzemis, Giardino, and McColgan (2015) divide the definition of child sexual abuse into two categories: physical contact activities or noncontact activities. Examples of sexually abusive contact activities include sexually touching a child over their clothes; touching a child’s genitals with an object; touching a child’s genitals with a body part; making a child sexually touch another person; anal/vaginal penetration with a foreign object; and oral/anal/vaginal penetration with a body part. Examples of sexually abusive noncontact activities are: sexual talk; asking a child to participate in sexual activity; exhibitionism; voyeurism (i.e., looking at a child’s naked body; asking a child to expose his or

her body; exposing a child to inappropriate sexual media; and engaging in sexual behaviors online.)

The term “abuse” implies that maltreatment is harm-producing and unwanted, however, researchers have included respondents that characterize their experience as neutral, mixed, or positive (Tromovitch & Rind, 2008). The rigid definition of unwanted incidents involving physical contact with a prepubescent person has not been used in any college or national studies (Tromovitch & Rind, 2008). Given that studies have not used this restrictive definition of CSA, it can be deduced that definitions are variably produced and inconsistent within the literature. Definitions of CSA continue to evolve and now include technological advances; in updates of reportable abuse conduct, sending sexual images through text messages is included as a reportable behavior (Miller-Perrin & Perrin, 2013). Definitions are also not restricted to non-consensual acts, as children may be pressured to keep a family secret or reduce the likelihood of family violence- especially if personal safety is threatened if the child does not comply with the perpetrator’s demands (Alaggia & Kirshenbaum, 2005; Collin-Vézina et al., 2013).

Reportable sexual abuse can be classified into two categories, sexual assault and sexual exploitation. Sexual assault includes: rape, statutory rape (when the offender is 21 or older and the victim is under 16 years of age), rape in concert (gang rape), incest, sodomy, lewd or lascivious acts upon a child under 14, or with a 14 or 15-year-old when the offender is at least 10 years older, oral copulation, sexual penetration, and child molestation. Sexual exploitation includes the act of employing, using, persuading, inducing, enticing, or coercing an individual to engage in sexually explicit conduct for the purposes of personal gain or profit. Sexual exploitation can occur online, through the use of technology, without the individual’s awareness.

Sexual assault indicates conduct in violation of one or more of the following: rape, statutory rape, rape in concert, incest, sodomy, or lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation. Conduct described as "sexual assault" includes, but is not limited to, all of the following: (a) Penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen; (b) Sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person; (c) Intrusion by one person into the genitals or anal opening of another person, including the use of an object for this purpose, except that, it does not include acts performed for a valid medical purpose; (d) The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that it does not include acts which may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose or; (e) The intentional masturbation of the perpetrator's genitals in the presence of a child (California Legislative Information, 2019).

For the purposes of this project, the WHO definition of child sexual abuse will be used, as it is more inclusive of behaviors or gestures that may be sexually abusive towards children. Although the definitions provided above represent various legal, academic and institutional criteria for defining child sexual abuse, these same definitions and criteria may not be consistent with laypersons' understanding. In addition to the pragmatic difficulties establishing a consistent definition of CSA, another limitation of existing research relates to the underlying assumption that all American ethnic and/or cultural communities share the same definition of child sexual abuse as other ethnic groups (Lowe Jr et al., 2005). These difficulties contribute to the need of

gathering a culturally sensitive understanding of child-rearing practices within other cultural and ethnic groups around the world. Sanjeevi and colleagues (2018) assert that understanding differences in child-rearing practices may help elucidate the differences in prevalence rates and attitudes toward child sexual abuse across cultures.

Perpetrator Typologies

Identifying the victim-perpetrator relationship plays a major role in understanding the nature of child sex abuse cases (Choi, Choo, Choi, & Woo, 2015). This is particularly important due to the significant impact on the duration, frequency, and/or severity of the abuse, as well as the victim's coping process after the abuse (Choi et al., 2015). The majority of child sexual abuse offenses are perpetrated by males (Thomas et al., 2013). While research is lacking on detailed descriptions on the types relationships between child and perpetrator, most articles provide typologies of perpetrators that fall within the following categories: parents, male relatives, family acquaintances (Thomas et al., 2013). Current literature falls short on distinguishing between different types of perpetrator in more detail than the categories listed above, and how these different relationships impact children and families differently. More generally, literature asserts that the more closely related victims are to the perpetrator, the less likely they are to disclose CSA (Alaggia & Kirshenbaum, 2005). Although all families of sexually abused children may experience a range of difficulties, one can presume that in cases of CSA where the perpetrator is a parent, family member, or trusted individual, families may experience more deleterious effects including betrayal, shame, guilt, impaired parenting abilities, withdrawal, and isolation.

Chapter 2: Review of the Literature on Families of Sexually Abused Children

Families are affected by the sexual abuse of their children in a myriad of ways. The impact of CSA on families is an often neglected and underexamined portion of the CSA literature as well as clinical focus. The impact on families is particularly important as family support can be a vital component of post traumatic growth for affected children. An overview of sociocultural factors related to FSAC and family dynamics are introduced and discussed below.

Intrafamilial Child Sexual Abuse

Intrafamilial child sexual abuse exists when the perpetrator is a legal guardian or parental figure (biological, step-parent or longtime partner), or someone who has a close relationship to the child victim (Hernandez et al., 2009; Peterson & Urquiza, 1993). Seto, Babchishin, Pullman, and McPhail (2015) indicate that up to one-third of child sexual abuse is perpetrated by family members. Of these intrafamilial cases, fathers and step-fathers are the most common type of offending relative. Mothers may also be perpetrators, however women are more commonly implicated in organized abuse; that is, knowing of the abuse, however, not protecting the child or assisting the male perpetrator (La Fontaine, 1993).

Hypotheses related to intrafamilial child sexual abuse propose that offending fathers or step-fathers are likely to take on an authoritarian, patriarchal role; the marital relationship is aloof and characterized as low in sexual intimacy and/or high in conflict; mothers are more likely to be dependent on the father, financially or otherwise; and some daughters are pushed into a surrogate partner role, not only sexually but also with regard to intimacy and household tasks, such as supervision and care of younger children (Seto et al., 2015). Clinicians and investigators have suggested that patriarchal attitudes and beliefs, emotional congruence with children, childhood difficulties with sexual abuse, poor attachment to parents, interpersonal deficits, and

psychopathology are important factors in explaining intrafamilial child sexual abuse (IFCSA) (Seto et al., 2015). The common theme across the first four explanations is that intrafamilial offenders often turn to children to meet their sexual or emotional needs, possibly because they themselves were victims of incest which may contribute to poor establishment and maintenance of healthy boundaries. The common theme across the next two explanations is that intrafamilial offenders are less able to pursue sexual opportunities outside the family due to interpersonal deficits or psychopathology and hence, their pursuits are limited to family members because they do not have the opportunity to offend against unrelated victims.

Intrafamilial sexual offending is clinically puzzling due to intrafamilial offenders frequently lacking antisocial tendencies and atypical sexual interests (Seto et al., 2015). Despite this, there is a dearth of literature focused on characteristics of intrafamilial sexual offending. Intrafamilial child victims have been known to be younger than extrafamilial abused children (Fischer & McDonald, 1998); this appears to be a consistent finding published literature articles. One explanation for this finding is that younger children spend a vast amount of time in the home and may be more accessible to family abusers compared to older children who split time at home, school, and other community activities (Fischer & McDonald, 1998). Fischer and McDonald (1998) also assert that intrafamilial sexual abuse undoubtedly persists for longer time periods of time compared to extrafamilial cases of child sexual abuse. This difference appears due to the much greater likelihood that the frequency of extrafamilial sexual abuse is often limited to a single incident (62.4%) whereas for intrafamilial cases, 23.5% involved a single incident (Fischer & McDonald, 1998). Again, some of the factors contributing to repeated incidences of intrafamilial child sexual abuse lie in the greater accessibility of children and decreased likelihood of disclosure when the offender is a family member or other trusted

individual. Research also suggests that cases of intrafamilial child sexual abuse advance more quickly than cases of extrafamilial abuse; that is, intrafamilial offenders engage in more serious forms of abuse from the time of initial onset of abuse. Fischer and McDonald (1998) discuss that penetration occurs earlier in intrafamilial cases whereas initial phases of extrafamilial abuse involve more fondling and less penetrative behavior. Researchers also indicate that extrafamilial abusers use more physical and verbal force whereas intrafamilial victims suffer more physical and emotional injury (Fischer & McDonald, 1998). This statistic may be due to the differences in intrafamilial and extrafamilial cases; intrafamilial cases involve longer duration of abuse, more intrusive abuse practices, and repeated, persistent patterns of abuse from their abusers. Instances where children are sexually abused by a parental figure, family relative, family friend, or any close other can be extremely confusing for the child, as adult figures are initially interpreted as a safe person who the child trusts instinctually. Identifying these factors and family dynamics is vital to understanding how much more a child may suffer from intrafamilial abuse, and by extension, the difficulties families face after abuse has been disclosed. Efforts to heal family wounds and recover caregiver ability to serve as resources to their children are critical factors for mental health professionals to consider in assessment and treatment of families.

The process of grooming as it relates to child sexual abuse relates to a behaviors that intentionally and deliberately lower the child's inhibitions, with the intention of preparing the child for sexual abuse or other exploitative, abusive behavior (Conway, 2014). Because most child abuse occurs by a known individual rather than a stranger, grooming is a common element that precedes the abusive behavior. Grooming can typically involve the abuser befriending the child and attempting to build a trusting relationship with the child with manipulation. As an

example, an abuser may give the child money or other desirable objects and presents. Once an adequate level of trust has been established, the abuser may begin to show pornographic images to the child, in an attempt to normalize the acts and behaviors the abuser would like to mimic in real life with the child (Conway, 2014; Tener, 2018). Moreover, an abuser may talk about sexual topics, engage in physical contact, and attempt to create opportunities to have time alone with the child. Threats of violence may occur, however Conway (2014) describes these threats as more practiced and confusing than a basic threat.

Tener (2018) discusses the negative familial or societal reactions that must be considered when attempting to understand the context of how IFCSA occurs. Involvement in a taboo secret such as intrafamilial child sexual abuse is a primary reason that abused children maintain secrecy; revealing such a secret would disrupt the entire social order (Tener, 2018). In addition to delaying disclosure, like many children who have been sexually abused do, those who are abused by relatives also receive negative reactions to disclosure, more so than those abused by strangers or acquaintances (Tashjian, Goldfarb, Goodman, Quas, & Edelstein, 2016). Family dynamics and family factors that may contribute to higher risk for child sexual abuse are discussed in the literature; however, specific factors as they relate to cases of intrafamilial child sexual abuse are missing in the literature. Tener (2018) provides information that negative family environments and dysfunction within the family (i.e. maltreatment) are barriers for disclosure in these cases, however, these are not unique to families of intrafamilial child sexual abuse (Collin-Vezina et al., 2013; Somer & Szwarcberg, 2001).

As it pertains to reactions after child sexual abuse has been disclosed, responses of non-offending family members are more commonly talked about in the literature compared to those of offending family members (Tener, 2018). Reactions that are more negative such as disbelief,

were noted for those victimized by relatives compared to acquaintances (Peterson & Urquiza, 1993; Skibinski, 1994; Tener, 2018). As the complex matter that child sexual abuse is, it is imperative that literature continues to explore intrafamilial abuse family factor dynamics and reactions to disclosure, due to this population being overlooked and under examined.

Impact of CSA on Non-offending Family Members

The existing body of literature suggests that the impact of childhood sexual abuse on family processes necessary to support the development of youth through adolescence is severe (Davies, 1995; Manion et al., 1996; Matsakis, 2004). Specifically, the intervention of child protective services and law enforcement, while serving to protect the child, rarely addresses the consequences to the youth of severing a parental relationship and the associated feelings of youth and non-offending parental self-blame (Kendall-Tackett, 2002). In other instances, discovery of youth sexual victimization serves to immobilize non-offending parents and reinforce perceptions of parenting incompetence and self-blame (Kendall-Tackett, Williams, & Finkelhor, 1993). Parents of sexually abused children experience significant levels of distress of various forms that occur independently of the child's experience of problems (Davies, 1995). While there is growing literature on the psychological impact of sexual abuse and sexual trauma on the child victims, there is a large gap in the literature for the impact on, and the needs of, non-offending caregivers and other family members (Banyard, Englund, & Rozelle, 2001; Hernandez et al., 2009; Hunter, 2006). This gap in the literature is critical given that caregiver support is a vital component to overall wellbeing and especially to individuals who have a victimization history (van Toledo & Seymour, 2016).

The population of non-offending caregivers of traumatized children has been largely overlooked, despite this being a population that is at risk for elevated levels of stress (Banyard et

al., 2001). This is reflected in the minimal amount of literature on this non-offending caregiver needs, and processes of a family's posttraumatic healing process. With the sheer number of individuals and families that seek mental health services and the high incidence rates of child sexual abuse, it is imperative that mental health professionals seek to understand the needs of this underserved population. Common non-offending parental reactions to the disclosure of sexual abuse include: guilt regarding perceived failure as a parent; ambivalent feelings toward the child; ambivalent feelings toward the offender; and concerns about the investigatory and judicial process (Regehr, 1990; Tener, 2018).

Families may be impacted by child sexual abuse allegations in other ways. Family members may have been aware of the ongoing sexual abuse and may have had their personal or family's safety threatened by the perpetrator, other family members may have been concurrently abused or sexually violated alongside the child, and family members may experience the contagion of stress after the child sexual abuse has been discovered (Banyard et al., 2001). Stress contagion is a commonly used term to describe the emotional phenomena of how others viewing or hearing of other's stressful and or traumatic experiences can create a so-called contagious physiological response in the observer. The effects of any traumatic event reverberate throughout the family system and a child's greatest need for love and support may come at a time when the trauma itself has compromised a family's ability to provide it (Corcoran & Pillai, 2008). Parents in the throes of traumatic stress reactions may question their ability to adequately parent their children and to maintain family routines and roles (Hunter, 2006). Parental withdrawal, overprotectiveness, excessive preoccupation with the trauma, ongoing anxiety and depression, or posttraumatic stress disorder (PTSD) symptoms can directly or indirectly exacerbate a child's traumatic stress symptoms (Hunter, 2006; van Toledo & Seymour,

2016). The emotional and cognitive responses of self-doubt, shame, guilt, withdrawal can co-exist or lead to the onset of psychiatric symptoms such as anxiety and/or depression. Other responses include decreased self-efficacy, self blame, betrayal, helplessness, hopelessness, and concern about the investigatory and judicial process.

When instances of intrafamilial child sexual abuse is disclosed and the abuser is a father or male-figure, caregivers are often faced with an emotional task of facing their intimate partner, a task that entails consideration of social, emotional, economic factors, and needs of the family (Massat & Lundy, 1998). Furthermore, caregivers are often cut off from social and family supports; as a result, they are likely to experience a loss of economic stability. This effect may be even greater for caregivers in which their partners were the identified abuser (van Toledo & Seymour, 2016). It has been found that the nonoffending parent's relationship to the perpetrator was the single biggest factor predictive of support for the sexually abused child (Massat & Lundy, 1998). Massat and Lundy (1998) coined the term *reporting costs* to describe the changes and losses that nonoffending parents experience or attribute to the disclosure of child sexual abuse; they categorize these reporting costs into four areas: relational, financial, vocational, and residential. Due to the high likelihood that in instances of intrafamilial child sexual abuse the child may have a central attachment to the abuser, relational 'costs' are a unique factor that affect families of intrafamilial abuse more so than instances of extra familial abuse (Massat & Lundy, 1998). Moreover, the negative opinions or stigma of intrafamilial abuse may be related to reduced levels of support from extended family, friends, or associates, which can affect the non-offending caregiver greatly. Further, when there are dramatic changes to a caregiver's intimate relationship (in cases of intrafamilial abuse), the ending of a relationship can be perceived as a major loss. With regard to financial loss, when the abuse is perpetrated by a family member who

is the primary income provider, the question of how to obtain basic needs may be a new stressor for a nonoffending caregiver (Schreier, Pogue, & Hansen, 2017; Massat & Lundy, 1998). For example, income is lost when the family offender moves out of the family home, discontinues making rent or mortgage payments, and no longer financially provides to other costs of living. Nonoffending caregivers often face stress related to having to acquire childcare, and transporting children to school, court, and therapy.

Caregivers have described the period following disclosure of child sexual abuse as stressful and they endorse a range of emotions (van Toledo & Seymour, 2016). Some common themes and experiences that parents and family members report following child sexual abuse disclosures include changes in perception of parenting ability (self-doubt), decreased self-efficacy, self-blame for the incidents that happened to their child, guilt, betrayal, hopelessness, and traumatic sexualization (van Toledo & Seymour, 2016; Celano, Hazzard, Webb, & McCall, 1996; Peterson & Urquiza, 1994). Caregivers also report an overall uncertainty about how to respond to changes in their child's behavior as a result of their abuse, including increased anger, regression, sleeping difficulties, insecurity, and increased sexualized behaviors (Davies, Seymour & Read, 2001). Disclosure of the abuse may also trigger memories of an adult family member's own abuse as a child and precipitate symptoms related to their abuse experience (van Toledo & Seymour, 2016). In addition to the serving the needs of the family members because of increased levels of distress, involving family members in treatment has been shown to have benefits on the child's wellness outcomes. There has been evidence that including the parents into treatment increases treatment efficacy for the child (Celano et al., 1996). Also, caregivers have identified that when they are provided with information related to abuse dynamics, how to support their child, the investigation process, long term outcomes of CSA, possible impact on the

family, and how to help maintain their child's safety, they are better able to give effective support (Davies et al., 2001; van Toledo & Seymour, 2016). When families are given individualized support to increase coping ability, and support on how to work through their own feelings of anger, guilt, denial, betrayal, powerlessness, resentment, and fear, they also report benefitting greatly (van Toledo & Seymour, 2016). These findings illuminate the potential to contribute to improvement at both the individual and family level when families are adequately and appropriately given coping strategies to manage personal stress reactions and the trauma reactions of children.

Assessing for the needs of the family unit has also gone overlooked within the literature. Needs are typically described within the context of caregiver or parent needs, however, needs of siblings and extended family members is largely understudied. According to caregivers, most of the abused child's siblings were affected in a variety of ways after finding out about the abuse behavior, which was described as "emotional difficulties" (van Toledo & Seymour, 2016, p. 410). Schreier and colleagues (2017) suggest that non-abused siblings can experience a variety of negative emotional and psychological effects, such as confusion and guilt, along with more tangible consequences like changing schools, moving residences, or interacting with law enforcement. Sibling responses to CSA can impact the victim's functioning and recovery abilities, which highlights the importance of treatment and intervention in supporting the entire family unit, not only child and caregivers. By incorporating siblings into abuse-specific mental health treatment, they feel not only supported by the caregiver's treatment seeking attitudes and efforts, but the sibling can also learn skills to be of additional support to their abused sibling (van Toledo & Seymour, 2017). Further research in the area would help identify other family factors to consider when treating caregivers and families of sexually abused children.

The underreporting of childhood sexual abuse suggests that there are many parents and caregivers who are left to care for a traumatized child without involving outside resources. There is a need for more personalized focus on the families and non-offending caregivers of children who have been sexually abused. There is also a great need for working with families using a strength-based approach and focusing on resiliency and creative coping. This is particularly important given that the larger family context in which children live and the amount of family support they receive following a trauma can be a powerful mediator between trauma and negative outcomes (Banyard et al., 2001). When asked whom caregivers went to for support, they reported receiving support from a range of sources including friends, family member or partner, counselor or psychologist, parents, doctor, church, nongovernmental organization, social worker, and schools (van Toledo & Seymour, 2016). While research has appeared to expand upon CSA in general, there are still areas for growth within the literature including increased focus on family treatment recommendations for non-offending caregivers and non-abused siblings.

Family Dynamics

Family dynamics are important factors to consider as they give clues and insight into an individual's functioning and experience, which rings especially true for children. More generally, literature on family dynamics and adult well being asserts that family characteristics such as cohesion (involved or disengaged), expression of emotion (ability to express, cope with, or resolve intense feelings), and conflict (avoidant or open expression of hostility), affect adult functioning (Alaggia & Kirshenbaum, 2005; Seehuus, Clifton, & Rellini, 2015). Other studies found that family environments, such as maternal care, family isolation, identification with mother, cohesion, and family functioning, influenced sexual attitudes and adjustment (Seehuus et

al., 2015). This area is understudied in the CSA literature and extant literature focuses on factors outside the family environment as they relate to CSA. The limited amount of research on the effects of family environment on sexual abuse is alarming given that family characteristics in childhood have been linked with many aspects of adult functioning (Seehus, Clifton, & Rellini, 2015). Theories often reference attachment theory, which argues that early interactions with caregivers affect the way that individuals relate to others and the self. Tromovitch and Rind (2008) suggested that sexual abuse is often a sign of an unhealthy or dysfunctional family dynamic. Following disclosure of CSA, family dynamics may change rapidly and rifts between members may develop, especially if family members do not support the victim or minimize the credibility of the allegations (Schreier et al., 2017). Schreier and colleagues (2017) suggest that in cases of intrafamilial CSA, family dynamics are especially sensitive and volatile. For example, victims may experience shame from extended family members, leading to a loss of those relationships both for the victim and for the supportive caregivers and siblings (Schreier et al., 2017). Siblings may be inadvertently placed in a precarious position, having to balance severed family relationships. As it relates to intrafamilial abuse specifically, literature has suggested that CSA tends to occur in families that are more disorganized and chaotic, have increased psychosocial stressors, and are more socially isolated compared to families without CSA and to families with extrafamilial offenders (Collin-Vezina et al., 2013; Schreier et al., 2017; Tener, 2018). Some of these same factors including conflict within the parent-child relationship, divorce, and low family cohesion, are associated with increased likelihood of depression and higher levels of sibling conflict (Schreier et al., 2017). Because these broader family factors may contribute to poorer outcomes among intrafamilial abuse victims, these factors may also place caregivers and siblings at greater risk for negative outcomes.

Sociocultural and Sociopolitical Considerations

Child sexual abuse has been established as a phenomenon that crosses all cultural, economic and demographic boundaries and has been substantiated as an international problem (Finkelhor, 1994; Sanjeevi et al., 2018). As such, it is critical to discuss the relevant sociocultural and sociopolitical issues pertaining to child sexual abuse including, but not limited to the age, ethnic background, religion, gender, and socioeconomic status. Cultural values that impact disclosure include but are not limited to, shame; taboos and modesty; sexual scripts; virginity; status of females; and honor, respect, and patriarchy (Fontes & Plummer, 2010). Understanding these values that are often held by individuals and within various cultural groups can enhance our ability to detect nuanced factors affecting CSA disclosure among different cultural groups. Still, it remains crucial to point out that although conceptualizing collectivistic and individualistic frameworks may be helpful, it is equally important to not allow these frameworks to define an individual's experience. Thus, macro-level conceptualizations of culture should be combined with nuanced understandings of culture as it pertains specifically to an individual or family (Sawrikar & Katz, 2017).

First, although lower prevalence rates of CSA among ethnic minority groups have been noted, this is likely more attributed to barriers of disclosure these groups face, rather than a genuine and substantially higher prevalence rate among Anglo populations (Sawrikar & Katz, 2017). Treatment and education that is targeted for Anglo communities due to the superficially higher prevalence rates may be an ineffective way of targeting population needs and by way of this, ethnic minority community needs are overlooked and ignored. Thus, a greater focus on the effects of CSA on ethnic minority communities, increased education, and specialized treatment recommendations for these communities should be developed further. The effects that CSA has

on individuals, families, and communities, and even how CSA is conceptualized, is largely influenced by sociocultural factors embedded into an individual's local social world (Kenny & McEachern, 2000).

One critical sociocultural issue that is relevant to CSA is related to overt gender and power inequalities woven into many collectivist cultures. Cultures that discourage assertive behavior, particularly by women and children, may perceive speaking against adults and/or men as disrespectful. As a result, people within these cultural contexts may refrain from using assertive communication styles and behaviors for fear of being perceived negatively within their communities (Kenny, Capri, Thakkar-Kolar, Ryan, & Runyon, 2008). Groups that may be affected by this include people of Asian, Latinx, African, and Native American, and Middle Eastern descent. These cultural beliefs undoubtedly contribute to decreased help-seeking from community resources. As a result, children may feel helpless and women may feel powerless if they are experiencing or witnessing abuse and come from these communities where visibility or access to resources is significantly limited.

Patriarchal values are also highly woven into the manner in which CSA is expressed in individuals, families, and the larger society. For example, in various cultures, fathers are often regarded as the head of the family; they hold the most power within the family unit (Sawrikar & Katz, 2017). In turn, he is most associated with the family's reputation. Instances of intrafamilial child sexual abuse can often go underreported due to the sheer power imbalance within controlling patriarchal communities. CSA can go underreported due to powerful male perpetrators of the abuse behavior that enforce a code of silence, fewer disclosures of child sexual abuse and perceived retaliation from powerful male figures in the family and community, or reported CSA that does not involve legal prosecution due to resources of powerful male

figures in and outside of the family unit. In a patriarchal society, male dominance and control are enforced beliefs that perpetuate the subordination of women, internalized oppression of women, and assertion of male power and privilege (Whittier, 2009). In light of this, sexual abuse of girls by men is more than problematic behavior; it is a systematic way of oppressing women that socializes and coerces women and girls until they acquiesce and accept ownership of their own subordinate status. These acts represent and maintain the oppression and dehumanization of women and girls; women and girls are viewed as property and objects for sexual use rather than equal human beings worthy of respect. Women remain powerless as individuals, within the family unit, and are viewed as second-class citizens within the larger society (Morris, 2009).

Additionally, children, by nature and definition, are powerless and reliant on adults and caretakers for getting basic needs met as well as ensuring their safety and survival. By nature of this dependent relationship dynamic and power differential, children are in a more vulnerable position to be abused. Moreover, it is important to realize that in different areas of the world, children serve different purposes (Sanjeevi et al., 2018). Reports of abuse can vary significantly even within countries when populations reside on islands versus inland, or are rural versus urban areas. The degree to which children are valued, how they are raised, and the expectations placed on them may vary significantly when moving, immigrating, or seeking refuge in a different region. Power dynamics within families, gender discrimination, and the varying roles and power that children have in different regions of the world, contribute to a variety of sociopolitical and sociocultural barriers for those affected by child sexual abuse. This may come in the form of sexual abuse allegations against fathers or other senior males that may be regarded as attacks against the entire family. Thus, in order to save the reputation of one's family it is often the

accuser and/or victim that is excluded by the family rather than the alleged abuser (Sawrikar & Katz, 2017).

Beliefs that children are not harmed or can even benefit from sex with an adult and beliefs related to sexual entitlement (e.g., “a person should have sex when it is needed”) are some examples of risk factors of a subset of antisocial attitudes that contribute to instances of intrafamilial child sexual abuse (Fontes & Plummer, 2010). Further, children who have been victimized by family members may choose to not disclose instances of sexual abuse due to foreseeable shame to the family, which is a crucial factor to cohesion and harmony in various communities. In traditional Latinx cultures, shame is a particularly powerful concept and when one lacks the moral compass to experience the appropriate self-critique for behavior that fails to meet community standards, one of the worst things to be called is *sin vergüenza*, which translates to English as without shame (Fontes, 2007). With shame being such a vital component to Latinx cultures, it unsurprisingly emerges in situations related to sexual abuse. More generally, child sexual abuse related matters are filled with shame for most people affected by it. Children feel ashamed because they have participated in taboo activities and behaviors and have maintained secrecy of these engagements. For Latinx families, involvement in child protective services or involvement with law enforcement can create, in and of itself, a deep sense of shame. Fontes (2007) describes the belief held by many Latinx individuals that only so-called bad parents would be questioned by authorities, and the inquiry itself can be a shameful accusation of parental inadequacy.

Ideas and beliefs related to sexual scripts are important to identify as they relate to CSA. Traditional values children are taught in a sexual education atmosphere include the notion that girls need to “keep their legs closed, because the boys are raised so that if the girls open them,

they're going to take advantage" (Fontes, 2007, p. 66). There is a gendered idea that boys have permission to do as they please and that they cannot control themselves, so the responsibility lies on the female to exercise so-called moral behavior. Latinx culture also emphasizes shame related to women speaking of sexual activity and sexual topics; merely mentioning genitals or sexual acts may be considered *muy bajo*, or vulgar when translated to English. Sex is viewed as "something females should try to avoid, and males should try to obtain from women and girls" (Fontes, 2007, p. 65). The value of a boy or man's masculinity may depend on the number of his conquests, and the value of a girl or woman's femininity is dependent on her chastity. These notions related to chastity, and female responsibility of sexually abusive behavior largely influences the sense of shame when it comes to CSA disclosure. These cultural beliefs directly influence the abused child and the family in which abusive behavior has been discovered. If girls are taught that they are responsible for guarding their chastity and that men cannot control their impulses, it is no surprise that girls may blame themselves when sexual abuse does occur. These culturally informed notions of sexual scripts are a vital component of posttraumatic growth and recovery for Latinx victims; learning and truly believing that they were not responsible for the abuse and reassigning blame to the offender can contribute to healing (Fontes, 2007). The same idea of shame can also apply to the experience a non-offending family member has after their child discloses CSA.

The centrality of shame in many cultures and ideas related to sexual scripts have been discussed above as they may inhibit disclosure of CSA and ultimately affect one's experience after surviving CSA. Religion may or may not be tied into these cultural values of shame and sexual scripts. Taboos that are religiously based can also impact perceptions of CSA and ultimately, inhibit disclosures (Fontes & Plummer, 2010). For example, children may avoid

prohibited words to explain the abuse that is happening and/or inappropriate behavior involving genitals. Fontes and Plummer (2010) provide various examples of how religious values influence disclosure of CSA. Such examples include a Catholic CSA survivor being told to attend confession and ask for forgiveness after she disclosed CSA from her brother (Fontes & Plummer, 2010). Further, children with religious beliefs may pray for the abuse behavior to stop and accept it as fate if it were to persist. In Buddhist cultures, individuals may attribute abuse to Karmic retribution for misdeeds committed in a previous life, thereby stigmatizing victims and their families (Fontes & Plummer, 2010). For individuals who proceed to report instances of CSA, a family's ruined reputation is a reporting cost too great to bear, especially for families that are deeply connected to their religious community/institution (Fontes & Plummer, 2010). Therefore, having unquestioned, deeply valued, and/or dogmatic religious beliefs may be a potential risk factor for children and families disclosing CSA.

Cultural notions of shame can also affect male victims in a particular way. Culturally, boys are expected to show sexual interest in women and girls at all times. Because of this, it may be increasingly difficult for boys to recognize that sexual behavior between an adult woman and a boy are exploitative (Fontes, 2007). Boys who have been anally or orally penetrated are prone to experience a heavy burden of shame due to participation in taboo behavior, but they may feel that their participation in these behaviors call their masculinity into question. Fontes (2007) identifies the mistaken belief held by many cultures that boys who have been abused sexually by men will later become homosexuals in adulthood. These cultural notions may affect not only the abused child but also the family unit. This may be a delicate matter for families that rarely discuss sex with open dialogue. It can be inferred that discussing these topics with family

members in a therapeutic setting requires insight into the cultural beliefs and a sense of patience and understanding when trying to discuss taboo topics with others.

The impact on individual, family, and community appears more pronounced in ethnic minority communities, due to the pronounced barriers and challenges to identifying CSA in these populations. For example, the aftermath of child sexual abuse appears especially pronounced in Asian cultures. Choi et al. (2015) assert that sexual abuse is reported to have the lowest prevalence rates within Asian cultures compared to other races and ethnicities. They explain that the specific cultural factors embedded into Asian cultures create the impetus for underreporting. Moreover, since disclosure of sexual abuse would likely bring family embarrassment, loss of family status and disharmony, a child's powerlessness and deference to elders would likely contribute to secrecy, underreporting, silence, lack of resources and unwillingness to obtain treatment (Choi et al., 2015). This is but one example of how sexual abuse concepts must be considered among an individual's local, social world, inclusive of sociocultural and sociopolitical systems. The particulars within an individuals' context must be considered due to the varying values within and among cultures, and the lack of existing research on these factors. Still, it remains crucial to point out that although conceptualizing collectivistic and individualistic frameworks may be helpful, it is equally important to not allow these frameworks to define an individual's experience. Thus, macro-level conceptualizations of culture should be combined with nuanced understandings of culture as it pertains specifically to an individual (Sawrikar & Kutz, 2017). Furthermore, acculturation could add to the already long list of cultural factors mitigating child sexual abuse perceptions, disclosure, reporting, treatment seeking, and community resources. One research study that exclusively examined the perceptions and experiences Hispanic women have with rape found that there may is within-

group heterogeneity regarding the rates of how often rape is reported among U.S. born Hispanics and those of Mexican ancestry. Specifically, for those of Mexican ancestry, the rates were roughly 11% for U.S. born Hispanics versus 4% for Mexican born women (Lira, Koss, & Russo, 1999). The discrepant rates of reporting could reflect aspects of acculturation (traditional Mexican women may be more hesitant to discuss such matters), selective immigration (Mexican women who experience sexual assault may be less likely to be able to migrate to another country), fear or distrust of authority on the part of immigrants (which leads to minding one's own business and not talking with researchers or other types of authority figures), or traditional Mexican culture (which may have protective elements against unwanted sexual contact (Sorenson & Siegel, 1992). Though this research focused primarily on adult women's experience of sexually abusive practices, acculturation and immigration related issues also pertain to CSA within Latinx families. Fears of deportation and distrust of law enforcement may take precedence over seeking justice for a child's sexual abuse. These findings highlight the need for clinicians to be aware of cultural factors that may account for shame, stigma, and other culturally-embedded notions of sexual assault and rape, whether the targets are women or children.

In addition to the power dynamics woven into CSA, gender-related issues as they relate to CSA are widely cited in the literature. Because the majority of child sexual abuse victims are female and perpetrators are overwhelmingly male, CSA can also be considered an extreme form of gender discrimination (Sawrikar & Kutz, 2017; Angelides, 2004). It is also vital to acknowledge that boys may be less likely to disclose sexual abuse for fear of stigmatization, fears associated with being labeled homosexual, and the mistaken desirability of engaging in

sexual practices with an adult woman; all of which may preclude minimization or denial by male victims (Alaggia, 2005).

Ecological models provide perspectives of understanding the occurrence of child sexual abuse, including risk of victimization and protection, as being mitigated by community factors (Ramírez, Pinzón-Rondón, & Botero, 2011). The variables of access to public utilities, recreation and health and education as well as the experience of and exposure to community violence, concentrated neighborhood disadvantage (including extreme poverty, residential instability, unemployment, high density of alcohol outlets), and weak social connections form a sociopolitical, sociocultural context that increases risk for child maltreatment (Ramírez et al., 2011). Social Disorganization Theory has arisen out of research associating community level characteristics with CSA. This theory emphasizes how population instability and socioeconomic disadvantage are critical factors that contribute to community problems (Greely et al., 2016). This theory adds that protective factors such as stable peer groups, after-school programs, and extended family networks are lacking in disorganized communities, and add characteristics that have significant risk potential for children (e.g., unemployed adults, transient populations). Additionally, the Centers for Disease Control and Prevention report that providing safe, stable, and nurturing relationships and environments for children and families can prevent child abuse (Centers for Disease Control and Prevention, 2019). Cultural and family factors such as social isolation, parenting stress, poor parent-child relations, negative family interactions, family disorganization, dissolution and/or violence are also considered significant risk factors (Centers for Disease Control and Prevention, 2019). As discussed, collectivistic cultural norms that preclude gender discrimination and powerlessness among children to “save face” may also mitigate availability and accessibility of services within one’s community.

Together, these particularities among and within individual, family, broader societal contexts and larger macro systems ought to be examined for their value in contributing targeted support and resources to affected children and families of sexually abused children. These varying factors suggest that highly individualized approaches are necessary for the diverse set of circumstances that surround those from culturally diverse backgrounds. Individualized attention to family, cultural, and sociopolitical contexts also lends itself to working from a strengths-based perspective with ethnically diverse families and individuals.

Strengths-based Approaches

Sexual victimization, although it is one of the most frequently studied forms of child maltreatment and victimization, includes a myriad of effects. Although the effects and aftermath of child sexual abuse has been associated with emotional and behavioral problems, internalizing factors and clinical presentations such as depression, anxiety, posttraumatic stress disorder, obsessive-compulsive symptoms, somatization, suicidal and self-injurious ideation and behavior, interpersonal problems, in addition to externalizing symptoms and disorders including substance use, high risk sexual behavior, aggression, conduct disorder, negative beliefs, and other interpersonal problems (Pérez-González, Guilera, Pereda, & Jarne, 2017). The American Association of Marriage and Family Therapists (AAMFT) advocate for a restorative approach to treatment rather than retribution (“Child Sexual Abuse,” n.d). Rather than implementing therapy designed to punish unwanted behaviors, (i.e., restricting contact amongst family members, threatening the removal of children, etc.) restorative therapy aims to create change by encouraging healthy relationships and boundaries within the family system. The underlying belief is that people are inherently good and that goodness can be restored to encourage strong, positive-valued, abuse-free interactions. AAMFT specifically identifies and advocates for

strengths-based and solution-focused interventions, however, no specific interventions or literature are mentioned by the association. Families and family members are described as competent and complex human beings; AAFMT states that family members are encouraged to engage in behaviors that build on their strengths and interests.

Approaches that focus on maladaptive beliefs about oneself (e.g. that one has no control over what happens to themselves) or others (e.g. that others are no good) interfere with the healing process. Recent studies have also suggested that as opposed to psychological interventions that primarily focus on symptom reduction, those that promote developing a strong self-identify may enhance personally meaningful recovery (Wright & Gabriel, 2018). This is a revolutionary idea in that it could be a person's understanding of their CSA experience and the meaning-making process achieved through therapy may be more important to the healing process than symptom-management or trauma resolution. Similarly, avoidance-oriented coping strategies appear to hinder recovery (social withdrawal, repression/denial of thoughts and feelings about the sexual violence) and clients may experience greater distress (Runyon, Spandorfer, & Schroeder, 2014). However, it is important to note that not all children and youth exposed to sexual victimization develop adjustment problems. With the identification and established research supporting the correlation of sexual victimization with these adjustment problems, more recent efforts have attempted to identify protective factors, resiliency factors, positive life changes, and healing by which the effects trauma can be mitigated (Draucker et al., 2009). Resilience is defined as the phenomenon or mechanism through which some individuals present relatively good adaptation despite suffering risk experiences that would be expected to incur serious and negative sequelae (Rutter, 2007). This has emphasized the importance and impetus for avoiding an overpathologizing bias by way of incorporating resiliency, healing, and

strength-based perspectives on treatment. Approaches that facilitate healing include strengthening beliefs that restore perceived control on one's recovery, restructuring cognitions that emphasize fear and likelihood of future attacks, and expressing emotions (Frazier, 2003). Current research posits that three sets of factors comprise the development of resilience: the attributes of children, aspects of their families, and characteristics of their wider social environments (Pérez-González et al., 2017). Specific protective factors have been identified including positive self-esteem, determination, sense of control or self-efficacy, processing of experiences, emotion regulation, control of thoughts and behavior, internal locus of control, achievement orientation, empathy, optimism and autonomy (Frazier, 2003; Pérez-González et al., 2017).

A strengths-based sociocultural perspective incorporates themes of posttraumatic growth and thriving, resiliency, personal well-being, improving overall quality of life, strength in the face of adversity, and building up interpersonal resources and strengths that may come from cultural beliefs and values (Tedeschi, Park, & Calhoun, 1998). Posttraumatic growth (PTG) is described as both a process and an outcome. Moreover, Tedeschi and colleagues (1998) discuss it as developing a cognitive process that is initiated to cope with traumatic events that cause an extreme cognitive and emotional toll. While a "seismic event" (i.e., a traumatic event) occurs on a psychological level, the remains of old structures that are largely demolished must be removed so that new, stronger structures can be built (Tedeschi et al., 1998). Coping with trauma often involves calling into question one's basic assumptions about the future and how to progress. The post-traumatic growth literature cites different areas of change including changes in perception of self, changes in relationships with others, and changes in philosophy of life that include a deeper appreciation for life, along with new life directions and priorities (Calhoun & Tedeschi,

1998). Other literature asserts that the essence of healing from sexual violence includes the following aspects: managing memories of the sexual violence, relating to important others, seeking safety, and reevaluating the self (Draucker et al., 2009). Drawing upon cultural and community strengths is also incorporated within recovery (Bryant-Davis, 2005). More specifically, disability, gender, migration status, race, religion, sexual orientation, and socioeconomic status are seven cultural categories identified by Bryant-Davis (2005) that are incorporated within the recovery model and addressed in trauma recovery work.

Recovering from the experience of CSA is an ongoing, multifaceted, complex journey. Within therapy, positive growth from trauma can include naming and acknowledging the experience as abuse, recognizing the impact of the abuse on oneself in terms of how one relates to themselves and others. While meaning-making is a vital component of any posttraumatic therapy, the literature appears to lack focused information on how meaning making affects individuals with CSA histories. Wright and Gabriel (2018) identify eight themes that impact posttraumatic wellbeing: trust; acknowledgement; evolution; acceptance; integration; congruence; relationships; and agency. Trust is often the first struggle individuals face after experiencing a traumatic event such as CSA. Learning to trust oneself and others has been shown to help individuals sexually abused as children have more successful and supportive relationships which alleviate a sense of isolation and enable them to feel heard, believed and not judged, which ultimately increases their ability to connect with others (Wright & Gabriel, 2018). The second theme of acknowledgement of the abuse and its impact was another helpful aspect found within CSA therapy work. Connecting the experience of abuse with the impact on feelings, thoughts, and behaviors in the present and past was helpful aspect incorporated into therapy. Draucker and colleagues (2011) found that as participants discussed their abuse, they

arrived at a more complex and multidimensional understanding; integrating the experience into a self-narrative is a pivotal part of meaning-making within therapy for CSA victims. The third phase of evolution is described as a phase where the survivor of abuse realizes that the experience of abuse was not their fault; reconsidering self-blame, feelings of guilt and shame are integral to posttraumatic growth therapy. The fourth theme of acceptance is discussed as a theme addressed in therapy where avoidant coping strategies such as self-harm, alcohol, and substance use are identified as an effort to deal with an “unwanted real self” (Wright & Gabriel, 2018). Part of gaining self-acceptance was learning about self-care and feeling at peace with one’s body, sexuality, and accepting what life has handed to them. The fifth theme of integration is discussed as a process of renegotiating gender constructs and creating an identity that integrated other parts of themselves into their sexual abuse history. Congruence, the sixth theme, is described as a process of creating new beliefs about themselves. This was done by understanding, discussing, and managing emotions by sharing feelings with others, including feelings related to abuse experiences. Individuals moved from incongruence between how they felt on the inside and what others perceived from their outward appearance to feeling congruent with internal feelings and perceptions and their external persona. Relationships with others is another theme often addressed within posttraumatic growth oriented therapy. By way of individuals learning to trust and connect with themselves, their relationships with others often improved. Managing relationships emotionally and physically, setting healthy boundaries, and learning about limits to relationships and accepting them was an integral part of working with individuals with CSA histories. Experiencing a greater sense of personal agency often involves shifting previously held beliefs about the world, as being hostile and dangerous, to feeling hopeful and excited about the future and one’s place in the world. Other feelings associated with

developing an increased sense of personal agency was discussed as feelings of empowerment, freedom, and the new ability to make choices and take control (Wright & Gabriel, 2018). By identifying these themes, one can see how new ideas of oneself and others are developed through posttraumatic, strength-based work with individuals. Though the eight themes discussed above relate to abused individuals, adapting these themes to work with caregivers and other family members would be vital to helping the family unit move in a positive, healthy direction of empowerment and recovery. By emphasizing the role of cultural intersections and drawing supports from these sources for each individual, this aids in the process of healing from sexual violence and trauma in order to provide a more personalized, strength-focused, and effective approach to the treatment of CSA.

Barriers to Treatment

There are various family and parent-focused treatments for child abuse that aim to improve parenting skills and communication more generally (Mendelson & Letourneau, 2015). Current treatments include “The Triple P,” and parent-child interaction therapy (PCIT). Other family-based interventions for addressing physical abuse include multisystemic therapy, Alternatives for Families: A Cognitive Behavioral Therapy (CBT), and Combined Parent-child CBT (Mendelson & Letourneau, 2015). Mendelson and Letourneau (2015) state that engaging parents in a CSA specific prevention program may be challenging for several reasons: the emotional intensity of the subject, stigma related to sexual activity, limited financial resources, time, and child care constraints. Moreover, the threat and stigma may also trigger fears of outside agency involvement by child protective services (Mendelson & Letourneau, 2015). Mendelson and Letourneau (2015) suggest embedding CSA prevention within existing family-based services and framing the intervention within the context of positive parenting more

broadly to help increase engagement and participation in services without increased fear and stigma. When families enter treatment, establishing rapport and trust with children and families is likely the first and most crucial aspect of implementing treatment and being able to successfully complete treatment.

Establishing and maintaining rapport. Extant literature has repeatedly ascertained the importance of the therapeutic alliance in facilitating positive outcomes in working with clients and families in a treatment environment (Yee et al., 2009). It has been well established that establishing rapport may help facilitate communication with children and encourage them to affirm and describe traumatic experiences in clinical, evaluative, or investigative interviews (Hershkowitz, 2009). The AAMFT asserts that when a family begins therapy, they want to feel safe and comfortable. Thus, therapists are encouraged to approach the family from a nonjudgmental stance and instead provide a safe environment to communicate with each other and the clinician.

Confidentiality. Confidentiality is often considered the hallmark of the therapeutic relationship; it is generally known that therapists maintain the privacy of their clients (Mannarino & Cohen, 2001). Managing the therapeutic alliance and abiding by ethical and legal principles within the American Psychological Association (APA) code of conduct can pose a difficult task for clinicians working with families and children. Limits of confidentiality include indications of threat to self and/or others, and reporting child and older adult abuse and/or neglect. This can cause some potential discomfort when treating families; fear of involvement of outside agencies such as child protective services, or law enforcement, can make it difficult to establish rapport and difficult to re-establish if confidentiality is broken and a report of child abuse is made by the treating clinician. Concerns pertaining to confidentiality also continue following reporting of

abuse. For example, child protective service workers may request treatment information from the clinician to guide decision making about family reunification (Mannarino & Cohen, 2001). These potential breaches in privacy may significantly deter families from seeking mental health treatment. Even still, when families present to treatment, establishing trust, rapport, and an optimal therapeutic alliance may be significantly more difficult due to ongoing fears of outside involvement. It may be difficult to establish rapport with abused children or affected family members for fear of being judged by others and undermining the ability that professionals will protect them (Ahern, Sadler, Lamb, & Gariglietti, 2017). Ahern and colleagues (2017) advocate that professionals interacting with youth should engage them in friendly, dependable, and flexible ways that make them feel cared for and heard. Acknowledging emotions, speaking openly about unthreatening topics before discussing trauma related details, and being patient with the client were identified as other helpful practices in establishing and maintaining rapport (Gilligan, 2015).

Training of Mental Health Professionals

MHPs are identified as mandated reporters under the Child Abuse and Neglect Reporting Act (CANRA). A mental health professional is any practitioner or provider who offers services to treat mental illness. MHPs include psychiatrists, psychiatric or mental health nurse practitioners or technicians, psychologists, marriage and family therapists, social workers, alcohol and drug counselors or other counselors, student trainees providing mental health services, and mental health paraprofessionals (National Alliance on Mental Illness, 2019). Although not all clinicians may opt to specialize in working with children where mandated reporting may be a consistent part of the clinician's responsibilities, it is important to note that *all* licensed clinicians must uphold their legal and professional duty to be aware of child abuse

issues including mandated reporting, definitions of child sexual abuse, and how to navigate child abuse and child sexual abuse as it may become a focus of treatment for adults who initially present to therapy with other presenting issues. The Child Abuse and Neglect Reporting Act (CANRA; Penal Code sections 11164-11174.4), is a California law requiring employers to identify mandated reporters and secure acknowledgement of their status and reporting obligations as a condition of their employment. Mandated reporters must report known or suspected instances of child abuse or neglect to law enforcement. Duty to report becomes mandatory once there is reasonable suspicion that abuse or neglect has occurred or is occurring.

Child abuse mandated reporter training. The California Department of Social Services along with the Office of Child Abuse Prevention has funded a project to provide free training modules for mandated child abuse reporters so that they may carry out their responsibilities properly. The website-based trainings have been available since 2010. Currently, there are three available training modules that are free of cost. The first is a general module that is non-profession specific and should be taken by all mandated reporters. The second module available is specialized for educators and school staff personnel, and is meant to be taken by all mandated reporters working in a school environment. Lastly, there are profession-specific modules for medical professionals, pre/post-licensed mental health professionals and social workers, law enforcement professionals, clergy, child care providers, as well as a Spanish language module for all mandated reporters (Child Abuse Mandated Reporter Training, n.d.).

The module specific to mental health professionals is a three hour-long training segment that is formulated to instruct mental health professionals on what to do if child abuse or neglect is discovered or if evidence is found, how to speak to children about suspected abuse, and addressing special issues related to child abuse reporting in the workplace. Vignettes are

provided for demonstration and a test that requires an 80% pass-rate is administered at the conclusion of training. Should a mandated reporter prefer in-person trainings, the project website also provides a schedule for in-person trainings with varying fees.

Specialized training in the treatment of sexually abused children. Trauma-focused Cognitive Behavior Therapy (TF-CBT) is one of the most commonly used interventions for child abuse with specific training available. It is an evidence-based treatment that has been evaluated for 25 years, and is used to help adolescents, children, and their families recover from the effects of trauma. TF-CBT is a structured, short-term treatment model that effectively improves a range of trauma-related outcomes in 8-25 sessions with the child/adolescent and caregiver. TF-CBT also effectively addresses many other trauma impacts, including affective (e.g., depression, anxiety), cognitive and behavioral problems, as well as improving the participating parent's or caregiver's personal distress about the child's traumatic experience, effective parenting skills, and supportive interactions with the child (Trauma Focused Cognitive Behavior Therapy, 2019). While TF-CBT was originally developed to address the needs of children who experienced sexual abuse, over the past 15 years it has been used and studied for many other populations of traumatized youth. Research now documents that TF-CBT is effective for diverse, multiple and complex trauma experiences, for youth of different developmental levels, and across different cultures (Trauma Focused Cognitive Behavior Therapy, 2019).

Clinicians have the opportunity to participate in TF-CBT online certification, provided at no additional cost through the tfcbt.org website. Although the website ascertains that obtaining the online certification is not a realistic measure of actual clinical competence in delivering TF-CBT, it does provide easily accessible tutorials, videos, cultural competency issues, and various interventions strategies.

The TF-CBT training has yielded positive results and has been adapted by a large population of clinical programs. In at least one randomized control trial, TF-CBT has been found to be superior to control or comparison treatment in improving children's PTSD symptoms (Cohen & Mannarino, 2008). Although it is described as a treatment model for trauma-impacted children or adolescents and their parents and caregivers (Cohen, Deblinger & Mannarino, 2018), there is room for growth in terms of adapting the treatment to be culturally sensitive, more strengths-based, and applicable to different affected populations. The inclusion of particular treatment components, specifically 'Psychoeducation and trauma impact' and 'Parenting skills to address children's traumatic behavior responses' are useful and applicable to parents, however somewhat narrow in scope. TF-CBT incorporates elements of cognitive-behavioral, attachment, family, humanistic, and psychodynamic principles as well as research findings about the psychophysiology of childhood trauma (Fitzgerald & Cohen, 2012). As it relates to this project, TF-CBT is described as a family-focused approach: parents and children are both included in this orientation with several conjoint child-parent sessions embedded into the curriculum. Attachment theory and family theory are particularly salient to this project due to the emphasis on a strength-based perspective of treatment. By focusing on rebuilding healthy attachments and conceptualizing the child and their experience as unique to the family environment, these elements of including family into the conceptualization are an important component of treating families with strength-based sociocultural perspectives in mind. Components of TF-CBT include psychoeducation, parenting skills, relaxation skills, affective modulation, cognitive coping, trauma narrative and cognitive processing, and enhancing safety and development (Fitzgerald & Cohen, 2012).

Child-parent relationship therapy with nonoffending parents of sexually abused children is another treatment modality that draws upon attachment theory and family perspectives. For children who have experienced a traumatic event, the caregiver-child attachment holds even greater importance (Bratton, Ceballos, Landreth, & Costas, 2012). Specifically for children that have experienced sexual abuse, maternal response has been shown to be particularly important (Bratton et al., 2012; Wamser-Nanney, 2018). Thus, interventions that seek to strengthen the mother-child bond, while also providing emotional support for the caregiver, seems relevant to fostering growth and family resiliency. Child-Parent Relationship Therapy (CPRT) is a play therapy based intervention that combines parental support and education to foster a healthier parent-child relationship (Bratton et al., 2012; Deblinger & Runyon, 2014). The relationship between mother and child thought of as a vehicle for effecting change in both the child and nonoffending parent. By improving a parent's sense of understanding how to respond to their child's needs, and by children learning to trust parents reliably and consistently, a child will see that they can turn to their parent for love, acceptance, and safety. The manualized treatment of CPRT includes theory related to child-centered play therapy (CCPT). The protocol calls for small group format of six to eight parents meeting to balance both supportive and didactic learning to maximize their success in applying the skills (Bratton et al., 2012). Initial treatment goals including creating an atmosphere of safety, acceptance, and encouragement, while simultaneously normalizing parents' experiences through sharing with group members. The first three sessions focus on learning basic CCPT skills including following the child's lead, reflection of feelings, and reflecting verbal and nonverbal content of child's play. Sessions four through 10 attempt to refine the skills learned through supervision of weekly parent-child play sessions. CPRT falls short of being considered a well established treatment and meets criteria for a

promising treatment, according to standards set forth by the APA (Bratton et al., 2012).

Outcome data for CPRT is significant for a beneficial effect on parental stress (Bratton et al., 2012). Although CPRT has been deemed as a “promising” treatment, there are a few areas it appears to fall short on. Child play is an integral part of healthy functioning and the CPRT protocol involving education and supervision of child-parent play appears useful, caregivers and parents may still require more in-depth treatment outside of receiving education, guidance, and validation for appropriate play behaviors. Future studies would benefit by evaluating outcome data when families participated in both CPRT protocol alongside adjunctive strength-based family treatments in both group and individual settings.

Child Sexual Abuse Curricular Guidelines

Given the prevalence and extent of Child Sexual Abuse, and its association with a range of psychological distress disorders, CSA has been identified as a significant public health challenge by the U.S. CDC (Wurtele & Kenny, 2010) necessitating attention and intervention by properly trained mental health professionals. In addition, there is a high likelihood that mental health professionals will come into contact with suspected or identified children of CSA, family members of a child affected by CSA, and perpetrators of CSA. Thus, there is a strong impetus for mental health professionals to acquire specialized training to detect, assess, and treat children, families, and perpetrators of child sexual abuse. Thus, mental health professionals should possess a clearer understanding of the processes that child sexual abuse survivors, families of child sexual abuse, and perpetrators of child sexual abuse experience, and all related issues pertinent to child sexual abuse and trauma. However, it appears that many mental health professionals who work with children and families have not been exposed to specialized training in child sexual abuse during their formal education (Kenny & Abreu, 2015). Although there are

a variety of mental health professionals that have varied professional activities, many will encounter issues pertaining to child sexual abuse. They often have direct contact with children and are viewed as child advocates, safeguarding children and possessing concern for children's welfare by virtue of their professional activities and ethics (Kenny & Abreu, 2015). These professionals play an important role in the evaluation period and the detection of abuse, enabling referrals for treatment or directly providing treatment to victims and their families (Crettenden & Zerk, 2012). In addition, they may work in agencies treating adults whose difficulties are the result of a history of CSA (e.g., substance abuse, eating and mood disorders).

Based on the magnitude of the problem and its association with a range of mental health outcomes, mental health professionals need to be adequately trained to work with these clients and be attuned to the unique issues surrounding victimization (Kenny & Abreu, 2015). Despite its prevalence, CSA poses a particular challenge to professionals as the signs and symptoms are often not obvious and disclosure is rare (Kenny & Abreu, 2015).

Prior to 1990, almost no universities offered courses in CSA; specialized information was only disseminated at professional conferences (Oz, 2010). Clinicians who completed their formal education prior to 1990 can be regarded as self-didactic (Oz, 2010). Nearly 20 years ago, research assessing exposure to child sexual abuse training found that of therapists who had been in practice 1-15 years, only 50% of them received training in treatment of child sexual abuse at their universities (Winkelspecht & Singg, 1998). In comparison, none of the therapists practicing for more than 16 years had received training relating to child sexual abuse, despite the entire sample reported having received continuing education. Further, of the entire 41 sample-size pool, 73% did not receive child abuse specialized training at their universities. In the training coursework of these therapists, 85% of the courses had treatment of child sexual abuse

as a topic that was covered under other course headings. These findings suggest that training in child sexual abuse has historically been a secondary concern and training focus of training (Winkelspecht & Singg, 1998). More recent research is needed to evaluate current training practices in educational programs for the various types of mental health professionals.

CSA training for mental health counselors and school counselors. Mental health counselors and school counselors are often employed in settings where they may conduct assessments on children potentially affected by CSA, or provide services to the affected children and their families. School counselors may serve the role of educating children and teachers about CSA, providing counseling services to children and their families immediately after disclosure, may informally serve as consultants for school regarding potential CSA and may bear the responsibility of providing other parent education programs and serving as liaison for other relevant CSA issues (Goldman & Padayachi, 2002; Kenny & Abreu, 2015). From a 1995 survey that gathered information from 96 randomly chosen U.S. graduate programs in counseling, only 42% of the programs offered a course that addressed child sexual victimization (Kenny & Abreu, 2015). It is important to note that for some of the programs that indicated child sexual victimization as being included in the curriculum, CSA issues covered were included in courses devoted to victimization issues as a whole or as issues related to counseling children as a whole. In a more recent study of all Council for Accreditation of Counseling and Related Educational Program (CACREP) courses, only 9 of the 50 programs that responded indicated that their program offers a course that specifically addresses sexual abuse (Kitzrow, 2002). The lack of recent research on training on CSA further attests to the need for specialized training within this domain. There is variability in professional requirements with respect to CSA. In California, The California Board of Behavioral Sciences (BBS), the state licensing agency for

licensed marriage and family therapists (LMFT), licensed clinical social workers (LCSW), licensed professional clinical counselors (LPCC), and licensed educational psychologists (LEP), has no specific requirements related to coursework on child sexual abuse (California Board of Behavioral Sciences, 2019). Further, licensing exam content areas do not address child sexual abuse specifically, but rather trauma and abuse more globally. With regard to continuing education, only LEPs are required to take a child abuse assessment and reporting course (7 hours in duration) for the first renewal of licensure (State of California, 2019).

CSA training for psychologists. Psychologists have a high likelihood of doing clinical work or working in settings that treat adults who have been sexually abused as children (Champion, Shipman, Bonner, Hensley, & Howe, 2003). Additionally, psychologists are also likely to come across family members of sexually abused children and perpetrators of CSA seeking treatment.

Despite the direct and involved role of psychologists in the treatment of children and adults who have been affected by CSA, little is known about the inclusion of CSA issues in psychology programs, as most of the research in this area has been focused on child maltreatment in general (Kenny & Abreu, 2015). A study from Champion and colleagues (2003) found that more than half of the programs surveyed covered child maltreatment in three or more courses in the curriculum. Despite this, the amount of attention that was paid to CSA as compared to other forms of child maltreatment was not reported. Research by Pope and Feldman-Summers (1992) surveyed psychologists from various APA divisions and ask about their training pertaining to CSA. The participants surveyed generally reported that their graduate programs and internships were deficient in providing adequate training for addressing sexual (and other) abuse issues. On a positive note, the participants with more recent training (later

graduates) provided higher ratings for their training than their preceding graduates (Pope & Feldman-Summers, 1992). Thus, as a profession that is so critically and closely involved in the treatment and recovery of individuals that may be reporting a history of child sexual abuse, it is alarming that graduate programs appear to have a lack of concentration on training of sexual and other types of abuse. Experience, training, and education on treatments for sexually abused children at any age is necessary to have competent and ethical treatment approaches for clinical populations.

CSA training for social workers. Social Workers bear the responsibility of having a critical role in the management and coordination of services for children affected by CSA as well as serving as liaison for families. A vast majority of social workers are employed by child protection agencies and are often involved in the consultation, identification, and report of abuse, as well as helping the family throughout the investigation, or providing direct services following the report of an incident (Kenny & Abreu, 2015). There are gaps in the literature pertaining to social work and preparedness or curriculum guidelines regarding child sexual abuse. Kenny and Abreu (2015) indicate that while the extent to which CSA is covered in social work curriculum is unknown, there have been efforts in the past to standardize the training social workers receive. The American Association for Protecting Children, a division of the American Humane Association, has developed a comprehensive, seven-module training protocol titled Child Sexual Abuse Curriculum for Social Workers which was evaluated by Cheung, Stevenson, and Leung (1991).

Expert Clinicians

The CSA literature points to the notion that specialized training is necessary for forensic investigators and training of allied professionals, such as teachers and nurses (Ericsson &

Charness, 1994). What seems to be lacking in the literature is the specialized training required of those individuals who guide the victims and survivors and their families through the maze of legal and other protection proceedings following the report of child sexual abuse, as well as the clinical work toward psychological healing and rehabilitation. Ericsson and Charness (1994) indicated that there was an absence of clearly defined standards of care and insufficient training in sexual trauma therapy. In their study, clinicians working with sexual abuse populations tended to be more generalist than specialist. Practitioners identified as CSA experts practiced clinically with children, adolescents, adults, and victims and offenders, and with families (Ericsson & Charness, 1994). Specialized training would promote community awareness of the fact that CSA clinical work is a distinct field. CSA specialization with appropriate training would ensure competent and safe therapy interventions for the CSA victims, perpetrators, and their families who seek professional help. However, given the prevalence of experiencing child sexual abuse, it is important CSA-specific training be accessible to all mental health professionals.

Webinar Training

A webinar, or web seminar, is a presentation, seminar, lecture, or workshop transmitted over the internet (Zoumenou et al., 2015). Over the past decade there has been a shift; instruction within the traditional classroom is no longer the only method of disseminating information. Now, with the advent of the virtual classroom, specifically as it pertains to the area of continuing professional education and among nontraditional adult learners, information can be distributed with ease to a larger audience with the provision of technological tools and equipment (Buxton, Burns, & Muth, 2012; Mayorga, Palis, & Bekerman, 2014). Many international and national organizations and associations now offer online learning options for free or at a charge

for members and non-members, including live webinars, archived webinars, and online trainings with certifications, which suggests an increased utility that is cost efficient and effective for disseminating information to a large body of individuals.

In a study on webinars for pharmacists, results suggest that the webinars received positive evaluations for the quality of the content, perceived value and relevance, and acceptance of the online delivery method (Buxton et al., 2012). Webinar format trainings are beneficial for several reasons: they facilitate diversity of instructors, as multiple presenters can all be virtually present from remote locations; they allow for a variety of presentation formats which can be engaging and inclusive of various teaching methods; also, webinars can eliminate budgetary costs associated with sustaining a robust and regular seminar program (Hamstra, Kemsley, Murray, & Randall, 2011). There are several advantages for using a webinar for training including (a) they are affordable; (b) they are flexible and convenient (you can log on from just about anywhere at any time); (c) they are interactive; and (d) they are effective (Carucci, Sharan, Heindrich, Bornstein, & Szelenyi, 2014). Thus, online platform training in the form of webinars appear to be a new and useful tool for widely distributing content and engaging audiences in a variety of instruction styles. A study exploring webinars found that ninety-seven percent of students strongly agreed or agreed that the webinar was informative and enhanced their course (Davis et al., 2012).

Overview and Rationale for the Research

This study proposed to develop an introductory webinar to serve as a training resource for mental health professionals on issues concerning non-offending family members of sexually abused children. The aim of the webinar series was to provide training modules from a strength-based, sociocultural perspective. Due to the high frequency of contact among mental health

professionals and those who disclose child sexual abuse, there is an established need for more research, effective training, and development of resources tailored to the unique needs of this vulnerable and under-studied population. The webinar aims to provide mental health professionals with information on strength-based treatment for family members of sexually abused children. This includes resiliency in managing stressors (i.e., minimizing exposure to triggers), and thriving factors that facilitate positive trajectories. The webinar is unique in its goal of addressing family members specifically, and encouraging this population towards more adaptive functioning and improvement in quality of life. A strength-based approach for this webinar series was selected due to its focus on adaptive skill building and resulting empowerment of clients that has been shown to be particularly important for those who are vulnerable and invisible within our society and overlooked in regards to being provided tailored mental health intervention (Calhoun & Tedeschi, 1998; Draucker et al., 2009). A webinar format was chosen for training purposes because it is readily available, easily accessible, distributable and therefore, has vast potential for wide dissemination across multidisciplinary fields. It is effective as a training tool for either new or seasoned clinicians. The webinar format is both flexible and convenient, important considerations for creating a training resource that is accessible to working professionals.

Chapter 3: Methodology

Introduction

The primary goal of this dissertation project was to develop an introductory resource for MHPs in a webinar format that would provide information to increase understanding and competence with respect to working with family members of sexually abused children. This webinar was intended to be a unique contribution with its emphasis on strengths-based concepts and perspectives, with added attention to sociocultural issues. A primary reason for initiating the development of this webinar was to address the gap in available literature, resources, treatment needs and recommendations, and clinical training pertaining to child sexual abuse matters and how it affects families of sexually abused children. It was anticipated that current training would benefit from additional attention to specific concerns and unique sociocultural considerations relevant to child sexual abuse.

The current chapter will describe the methodology that was used in the development of the webinar. It should be noted that the webinar described here was initially designed to be a segment of a comprehensive webinar focusing on different aspects of CSA that included a focus on sexually exploited minors (e.g., trafficking; Janicic, 2018) and perpetrators. The broader goal was for MHPs to become more attuned to the unique treatment needs and obstacles faced by those affected by CSA. By providing a webinar training targeting the different sub-populations affected or involved in childhood sexual abuse in a culturally responsive and strengths-based manner, clinicians may become more adept at addressing their clients' needs. The scope of this dissertation project solely included the development of the webinar content and format for working with FSAC. Integration of all modules and dissemination to mental health professionals will be part of potential next steps.

The initial phase of this project included an extensive review of available literature, research studies, and online resources that would provide the foundation of information to be included in the webinar training. Literature was gathered from topics concerning prevalence rates of CSA, how CSA is disclosed, barriers to CSA disclosure, types of CSA, deleterious effects of CSA, roles of mental health providers as it relates to CSA matters, sociopolitical and sociocultural issues as they relate to CSA, strength-based approaches and concepts, impact of CSA on caregivers and families, treatment approaches for families of sexually abused children, information on available training for various MHPs, and the utility of webinar trainings for clinical training purposes. The second phase of the project involved gathering information from MHPs regarding existing CSA training and the perceived gaps in training needs in order to further clarify and consolidate material for inclusion in the webinar training. Following this phase, information gathered from the literature review as well as the feedback from MHP surveys was integrated into the development of the introductory webinar training resource. Lastly, the final webinar training resource was submitted for evaluation by one expert MHP.

Review of the Literature and Existing Resources

The initial phase of the project (literature review) that informed the content of the webinar resource included information sourced from databases such as PsycINFO, PsycARTICLES, ProQuest, Sage Journals Online, Science Direct, Elsevier, Ebsco Host, SpringerLink, PubMed, Research Gate, Routledge, Worldcat, Dissertations and Theses, Education Full Text (Wilson), Scopus, Wiley Library, books in print, and various internet resources. Information from local and national organizations affiliated with child sexual abuse were also included, including National Child Traumatic Stress Network (NCTSA), Rape, Abuse & Incest National Network (RAINN), Darkness to Light, American Trauma Society, National

Center for Victims of Crime, National Children's Alliance, The Center for Disease Control National Prevention Information Network, National Alliance on Mental Illness (NAMI), Parents Protect!, and Stop it Now! The review of literature focused on child sexual abuse, treatment, sociocultural factors pertaining to FSAC, current training for MHPs as it pertains to sexually abused children and their families, and strengths-based treatment concepts for CSA. Keyword searches included a variety of combinations of the following terms: sexually abused children, youth, and minors; sexual victimization; child maltreatment; intrafamilial sexual abuse; child welfare; non-offending caregiver; siblings of sexually abused children; non-abused siblings of sexually abused children; intrafamilial perpetrator; transgenerational sexual abuse; incest; child molestation; and cultural considerations of CSA. Keyword searches also included various combinations of the following treatment-related and training-related terms: family treatments of CSA; stress contagion; trauma and resiliency; posttraumatic growth; family protective factors; positive psychology for child sexual abuse; and strengths-based intervention. A review of empirical findings pertaining to FSAC was gathered to aid in developing a comprehensive understanding of the aforementioned population. Literature regarding treatment approaches and considerations, namely strength-based approaches with consideration for sociocultural perspectives was a particular focus of the review. Additionally, a review of information pertaining to MHP training and utilization of online training platforms was conducted.

Webinar Development

In order for psychotherapeutic interventions to achieve their maximum potential public health impact, it is important that mental health clinicians benefit from training in various types of interventions for a broad range of populations and presenting problems. Clinical training typically involves developing competence in delivering a large number of complex intervention

components that is usually addressed through comprehensive and expensive in-person training programs (Powell, McMillen, Hawley, & Proctor, 2013). Unfortunately, the expense and intensive nature of these in-person trainings pose serious problems in accessibility and scalability (Powell et al., 2013). Intensive day-long trainings may be exhausting for clinicians, with decreasing attention and energy that impedes sufficient learning and engagement from occurring. In a recent study, Powell and colleagues (2013) indicated that mental health clinicians expressed a growing desire to receive online training, citing the ability to take a training course at home at a convenient time and at their own pace as motivators to receive training through web-based platforms. Currently, web-based training is increasingly being used in health, educational, and business settings as an effective, low-cost alternative for teaching and training purposes.

Trainings offered through online platforms have been a rising trend in sectors including business and medicine. By employing the use of a webinar, disseminating, discussing, sharing, brainstorming, and collaborating with a vast amount of people becomes possible with the mere click of a button. It is common practice for webinars to contain both live audio and video feed in order to engage with participants, foster discussion, answer questions, and elaborate on content. However, it is also common for webinar presentations to utilize a pre-recorded audio voiceover synced with the visual presentation, such as a PowerPoint. With the advent of integrated web platforms, audio, video and chat features can be a helpful addition to making a successful, engaging, and informative presentation (Buxton, Burns, & De Muth, 2012; Carucci et al., 2014). The rationale for webinar versus in-person training was simple: webinars can reach a greater amount of people, are cost-effective, and are an equally useful way of disseminating information (Zoumenou et al., 2015). The use of technology makes these connections possible, allowing connection with professionals and experts around the world outside of typical work hours, at

school, or in the comfort of one's home (Buxton et al., 2012; Coiffe, 2012). The content of the current webinar training was formatted in a PowerPoint presentation structure. This format is user-friendly, familiar, and allows for dissemination of the webinar content to a large number of mental health professionals. Given the variety of settings in which MHPs practice and busy schedules clinicians' maintain, formatting the content for potential webinar dissemination appeared to be the most practical way of structuring information.

Although the webinar content of this current project will not be privately hosted, it will be formatted in way where it can be uploaded or easily shared through webinar training platforms, or YouTube Live, which is a simpler and more cost-effective alternative to expensive webinar software platforms. Webinar trainings can be hosted through YouTube Live without limits on number of attendees, advertisements distracting the audience, or paying a premium fee even if the platform is only used occasionally (Gonzaga, 2014). Should future projects be interested in publishing the webinar content, YouTube Live offers many benefits of webinar hosting. Future webinar hosts can determine a broadcast date and time, and send notifications through email regarding the planned broadcast scheduling. YouTube Live stream options will also allow attendees to add typed commentary in the chat feature. Here, attendees can provide feedback, personal anecdotes or relevant clinical experiences. Due to the public nature of YouTube, confidentiality statements will be announced at the beginning of the webinar. It is important to note that in addition to the YouTube Live broadcast, the presentation can be downloaded into MP4 format and shared onto other networks, creating a snowball effect and maximizing potential webinar dissemination. Once the live webinar stream has concluded, users can post questions onto the YouTube video page, so that the webinar moderators can answer by commenting on posted questions and statements.

The proposed duration for the webinar training is approximately 30 minutes. As noted previously, this project was created simultaneously with other researchers' webinar developments for other sub-populations related to child sexual abuse: sexually exploited minors (Janicic, 2018) and perpetrators of child sexual abuse. The initial intention was to create a larger two-hour-long webinar training spanning five modules reflecting a brief general introduction to child sexual abuse, three sub-populations related to CSA (sexually exploited minors, perpetrators of child sexual abuse, and families of sexually abused children), and a final Q&A portion.

Contribution from Mental Health Professionals

A needs assessment survey of mental health professionals was conducted to gather information relevant to CSA training with attention to each of the three populations of the larger webinar. The focus of the methods described here will be on the aspects of the survey relevant to existing training and perceived needs in the treatment of child sexual abuse as it pertains to families of sexually abused children.

Sample. Using convenience and snowball sampling methods, a sample of 21 MHPs was recruited to complete a survey regarding specific CSA training needs with respect to sexually exploited minors (SEMs), perpetrators of child sexual abuse (PCSA), and families of sexually abused children (FSAC). For this study, sample data was solicited and collected from MHPs licensed in the United States with Master's and Doctoral level education. Master's and Doctoral level MHPs are licensed at the state level with respect to each state's own requirements. Criteria for inclusion in the study included: 1) the practitioner must be a Master's or Doctoral level mental health professional, 2) the practitioner must be a mental health professional in the United States, and 3) the practitioner must be a licensed mental health professional.

Recruitment strategies and procedures. Participants were recruited in accordance with the approved application to the Institutional Review Board (IRB) of the host university. The proposed project utilized a web-based survey for data collection. Web-based surveys offered researchers a low-cost option for data collection. Web-based surveys are time efficient, convenient to access and distribute, and reduce errors from coding (Umbach, 2004). The web-based survey questions obtained information related to educational background, years working in the mental health field, settings in which they work, information on specialized training received through their training program (coursework), didactic presentations, and continuing education. Feedback on MHPs' training needs as it pertains to sociocultural and strength-based perspectives for FSAC were also topic areas within the needs survey. Gaining cooperation of contacted individuals' survey participation is essential to the success of the self-administered data collection methods, such as the online MHPs' needs survey (Keusch, 2012). Studies pertaining to web-based surveys suggest a scatter of response rates, but many appear to indicate the increased rate of responding when survey reminders are sent to participants, or when there is increased engagement with the participants (Keusch, 2012; Nair, Adams, & Mertova, 2008; Umbach, 2004). Based on this projection, if no follow-up emails are sent, one can expect a response rate of approximately 30% (Umbach, 2004).

A convenience sample of mental health professionals was contacted through email and invited to complete the online survey. Initial recruitment efforts began by contacting the researchers' affiliated university, to distribute the survey widely amongst faculty and students. Further, clinical training sites that maintain training contracts with the university were contacted for survey recruitment. This list of clinical training sites was obtained from the Director of Clinical Training through the host university. Convenience sampling efforts also included

emails to APA-accredited universities and professional school training programs as well as current and past clinical training sites and other personal and professional contacts that meet the survey participant requirements. In order to increase the amount of completed surveys and meet a goal of 20 completed surveys, recruitment emails kindly asked that survey responders distribute the online survey link widely to mental health professionals in their networks (see Appendix A). This initiated a snowball sampling strategy that was intended to yield additional survey responses. This sampling strategy allowed access to multiple MHP's simultaneously, as both training programs and clinical training sites typically have numerous listed MHPs on staff. After the initial recruitment wave, less than 20 responses were received. Thus, a secondary wave of recruitment followed by sending recruitment emails to additional APA-accredited training programs, sites, and mental health professionals in affiliated networks. During the data collection period, the amount of completed surveys was monitored on the survey platform website to determine if additional recruitment emails were required to meet the sample size goal. Responses were reviewed until the minimum goal of 20 completed surveys was obtained.

Recruitment emails informed the potential survey respondents that their participation was voluntary. When participants agreed to click on the survey link, the first page of the survey included an informed consent statement to inform participants that their responses will remain anonymous should they choose to proceed with the survey. The recruitment email also informed potential participants that the survey should take approximately 10 minutes to complete. A brief overview of the purpose of the study was provided in the recruitment email along with contact information for the researchers and dissertation chair should interested parties have additional questions prior to completing the survey. The survey link was pasted into the body of the recruitment email, where participants were taken to the informed consent page that was the first

page of the online survey (see Appendix B) to decide whether they wanted to continue with the training needs survey. Lastly, potential participants were provided with email contact information (a *Gmail* account was created specifically for the purposes associated with this dissertation project) and they were invited to contact the researchers if they had questions or concerns.

Mental health professional training needs survey. The online survey (see Appendix C) included a variety of questions pertaining to MHPs' credentials, experience and history working with the specified populations, and quality of training with respect to various population needs and sociocultural considerations. The survey comprised of 16 items and included both open-ended questions and forced-choice formats. The initial survey questions were aimed at gathering general and demographic information of the potential participants, including licensure status, type of license, and years of experience working in the field of mental health. Survey questions then became more targeted and sought to obtain specific information related to MHPs' experience in relation to working with FSAC. Potential participants were asked how many years of experience they had working with FSAC and were asked about specific skills that they found most helpful in working with this population. Respondents were asked about specialized training received related to working with FSAC and whether such training was perceived as sufficient or adequate. Survey participants were asked to identify sociocultural factors relevant to working with FSAC. One survey question asked, have you received training in any of the following areas in relation to working with families of sexually abused children? Response options were: thriving in the face of adversity; post-traumatic growth; resiliency; sociocultural context; well-being; empowerment; positive psychology; or other. At the conclusion of the survey,

participants were asked to share specific information they deemed necessary for future trainings or continuing education in relation to work with families of sexually abused children.

Analysis of survey responses. Once the researcher reached the goal of obtaining at least 20 completed surveys and the data collection period closed, survey responses were reviewed. Data analysis included running descriptive analysis to understand the patterns of responses. The data was reviewed for content and all suggestions (regardless of their frequency) were considered for inclusion in the webinar training. The purpose of the brief needs survey was primarily for gathering additional details, feedback, and ideas for training needs from the perspective of licensed mental health professionals. The data collected and analyzed was not meant to be a representative or random sample nor was the data intended to be a reflection of what all mental health professionals think about CSA training needs.

Webinar Training Resource Development

Once a thorough and comprehensive review of the literature, review of existing resources, and review of data from the MHP training needs survey was completed, the webinar training resource content was developed. This webinar training is a standalone module pertaining to families of sexually abused children (FSAC). This webinar curriculum includes an overview of child sexual abuse, reviews pertinent information related to families of sexually abused children, identifies sociocultural elements of CSA, and reviews current family treatments and recommendations for strengths-based family interventions for FSAC.

Training module: families of sexually abused children. This module began by introducing common elements that emerged from the literature pertaining to childhood sexual abuse more generally. The module provided a rationalization for the current project and identified gaps in the literature that pertain to CSA and FSAC. This module incorporated an

overview of basic information about child sexual abuse including prevalence rates, definitions, relevant terminology, and the short-term and long-term effects of CSA based on developmental factors. The webinar training also identified the addition of reviewing relevant sociocultural and sociopolitical factors as they relate to CSA.

In order for MHPs to increase their knowledge, clinical competence and cultural competency related to treating FSAC from a strengths-based perspective, common themes, elements, and treatment implications gathered from the literature were included in this webinar curriculum. The training was organized and presented in the following sequence: introduction, purpose, identifying learning objectives, discussing training needs for MHPs, MHPs responsibilities related to CSA, CSA definitions and prevalence rates, factors affecting delayed disclosure, sociocultural/sociopolitical considerations, family dynamics and correlates of CSA, intrafamilial child sexual abuse, impact of CSA on family members, nonoffending parent needs, strengths-based assessment and treatment considerations for FSAC, two case vignettes, resources, and a selected reference list. As there are limited strengths-based treatment protocols or curriculums specifically tailored for working with families of sexually abused children, the contents of the module drew from current practices for working with families from a positive psychology perspective and adapted the information accordingly as it pertains to families of sexually abused children.

Evaluation of the Webinar Training Resource

Once the webinar content was completed and reviewed, recruitment efforts were initiated in order to obtain preliminary evaluation data from a single MHP expert. Specifically, recruitment was purposeful and targeted program directors and so-called experts in the field of family treatment of CSA. Potential evaluators were contacted by email and invited to complete a

brief online survey regarding the relevance, usefulness, and areas of weakness/strengths of the webinar training resource.

Sample. The webinar evaluator was recruited in accordance with the approved application to the university's Institutional Review Board (IRB). In order to be deemed eligible as an expert mental health professional, one or more of the following criteria was required: (a) a licensed mental health professional with at least 20 years of experience with treatment of families, or he/she is (b) a director (or previous director) of a program that focuses on family treatment, or (c) published in relation to family treatment within the past 10 years.

Recruitment strategies and procedures. The first recruitment effort targeted mental health professionals who had published in relation to family treatment within the past 10 years and program directors of family treatment programs. An internet based search was conducted for programs that focus on family treatment of child abuse and a list identifying mental health professionals that have recently published in relation to family treatment within the past 10 years was compiled. Three experts (program directors or published authors) who met the inclusion criteria were identified and contacted in random order. Each potential evaluator was contacted through e-mail to explain the overarching goal of the research project, and purpose of the webinar training resource (see Appendix D—Invitation to Webinar Training Evaluation Survey). Within each email requesting mental health professionals to serve as expert evaluators, the researcher requested that the invitees disseminate the invitation to other MHPs who meet criteria to serve as evaluators. MHP invitees were informed that their participation to serve as an expert evaluator was completely voluntary and that personal information would be de-identified. It was stated that the approximate time to review the webinar resource content would be no more than one hour; it was also stated that it would take approximately 10-15 minutes to complete the

evaluation survey (see Appendix B). Within the content of the invitation email, the evaluator was provided with a link to the webinar training curriculum and content, and a link to the accompanying evaluation survey. The initial potential evaluators declined participation and the recruitment was expanded to include networks known to the researcher and chairperson. A participant with relevant experience treating families of sexually abused children was secured as the expert evaluator through this strategy. The participating evaluator reported having served as a program coordinator (of a program that focuses on family treatment) and reported having 14 years of relevant experience. Although the evaluator had less than the 20 years experience indicated in the initial inclusion criteria, the individual served in leadership and supervisory roles in working with issues of sexual abuse. The participating evaluator was given a \$20 gift certificate to Starbucks as compensation for their time, and for completing the Webinar Training Evaluation Survey in its entirety.

Evaluation survey. Questions in the evaluation survey elicited feedback regarding the evaluator's perceptions of curriculum content accuracy, as well as effectiveness and usefulness of the webinar training. Feedback was also solicited pertaining to the layout, design, and overall structure of the webinar training. The evaluation gathered specialized feedback regarding the webinar content for FSAC. The structure of the evaluative survey included open-ended questions with comment boxes as well as likert-scale questions. The comment boxes allowed for additional feedback or suggestions that pertained to any portion of the webinar training resource (see Appendix F). The evaluation survey comprised of 11 questions. Potential evaluators were asked to rate the degree to which the webinar was informative, focused and specialized for training MHPs to work with FSAC, and whether it is most useful for early-career MHPs, mid-career MHPs, or late-career MHPs. Potential evaluators were also asked to discuss in what ways

did the webinar training contribute to their knowledge base, understanding, or readiness to treat FSAC. The potential evaluator was also asked to provide their feedback on the strengths-based perspectives on treating FSAC that were included in the webinar. Specifically, one survey question asked- in what ways do you think the strengths-based perspective is beneficial in informing mental health professionals' current/future treatment of families of sexually abused children? The potential evaluator was asked to rate the applicability of the sociocultural and sociopolitical components of the webinar training to current or future treatment of FSAC. The potential evaluator was asked to rate to what degree did the webinar training increase their appreciation for the complex nature of CSA and final comments and suggestions for modification of the webinar were solicited. Lastly, potential evaluators were informed that the current project was created simultaneously with other researchers' webinar developments for other sub-populations related to child sexual abuse: sexually exploited minors and perpetrators of child sexual abuse. As mentioned previously, the initial intention was to create a two-hour-long webinar training spanning five modules reflecting a brief general introduction to child sexual abuse, three sub-populations related to CSA (sexually exploited minors, perpetrators of child sexual abuse, and families of sexually abused children), and a final Q&A portion. The final survey question invited the potential evaluator to comment on their impressions about the value of presenting these three populations together.

Analysis of evaluator responses. Once the researcher reached the goal of securing one evaluator and received a completed webinar evaluation survey, survey responses were reviewed. Data analysis included a close review of feedback of the ratings and qualitative responses provided.

Chapter 4: Results

MHP Training Needs Survey

Demographics. A total of 21 total participants completed the mental health professional needs survey in its entirety. Results from the completed surveys were analyzed for frequencies and descriptive statistics using the Statistical Package for the Social Sciences (SPSS, version 24). Among the 21 respondents, current job titles included: assistant professor/psychology doctoral trainee, associate professor of psychology, clinical coordinator, clinical counselor (2), clinical director, clinical psychologist (2), forensic psychologist, HUB/MAT clinician, internship program coordinator, licensed marriage and family therapist (2), licensed professional counselor, psychologist, quality assurance specialist, staff psychiatrist, staff psychologist (2), and staff psychologist/ assistant training director. See Figure 1 below for a breakdown of current positions held by survey participants. All 21 participants responded, “yes” to current licensure. In terms of type of licensure, participants included the following: Participants varied in terms of years of experience in the mental health field with responses ranging from 5-20 years. Nine participants indicated current or previous clinical work with families of sexually abused children. Eight of the nine participants with a positive history of working with FSAC indicated the specific amount of years working with this population. Specifically, respondents indicated 1 year (2), 3 years, 5 years (3), 9 years (1), and 15 years (1) of experience working with this population.

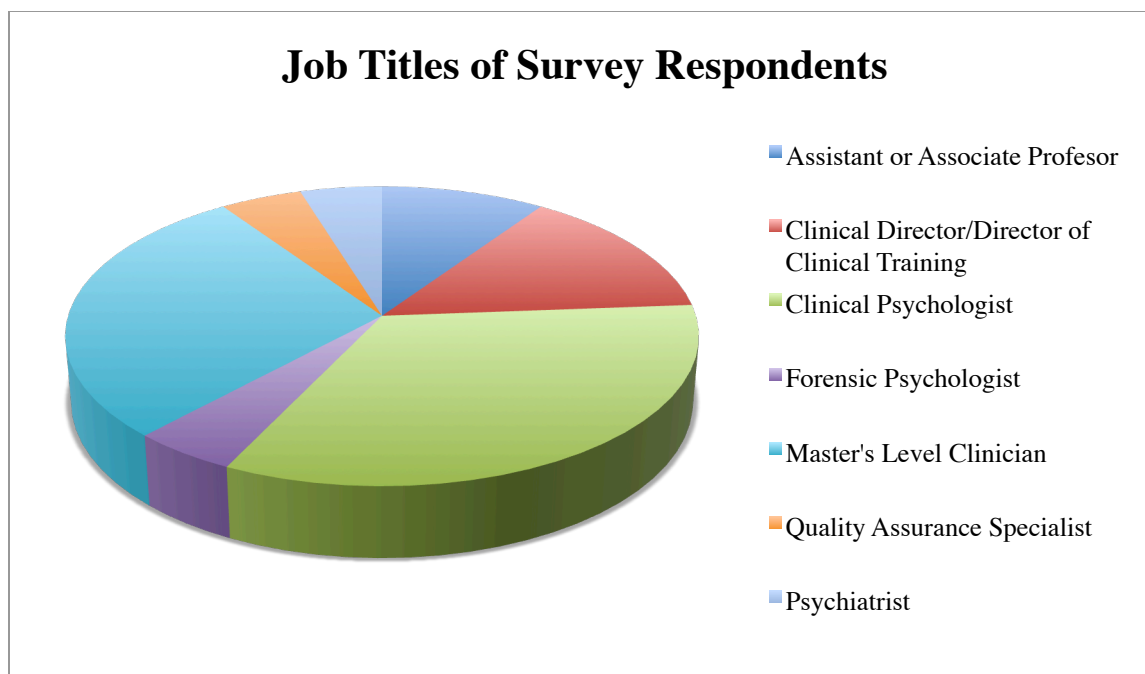


Figure 1. Job Titles of MHP Needs Survey Respondents.

Clinical needs and training received. Questions within the web-based survey gathered information related to previous training experiences. As it pertains to working with families of sexually abused children, two survey participants endorsed receiving specialized training and 18 indicated having no specialized training. Of the two participants who reported receiving specialized training, such training was received through continuing education and trauma-informed evidence-based practices. One survey participant indicated that the training received was adequate in preparing them to work with families of sexually abused children; four survey participants indicated no, and 15 responded, “N/A.” Participants were also asked whether or not they have noticed any gaps in their training, including skills needed to work with FSAC. There were a total of 16 responses to this item; six indicated “yes” and 10 participants indicated “no.” Of the responses that indicated “yes,” participants included specifics that more training is needed overall and earlier in the career. One participant noted that although they have been able to use components of TF-CBT to address trauma, “more specific training would have been helpful.”

See Table 1 for a summary of results related to specialized training for FSAC and perceived gaps in training.

Table 1

MHP Clinical Needs and Training Received

FSAC Specialized Training	<i>N</i> = 20	%
MHPs with specialized training	2	10.0
MHPs without specialized training	18	90.0
Gaps in Training	<i>N</i> = 16	%
Perceived gaps in training	6	37.5
No perceived gaps in training	10	62.5

Several survey questions solicited information related to specialized training obtained, useful skills, and perceived gaps in training relative to working with families of sexually abused children. A total of 13 responses were provided that detailed various skills deemed relevant to working with FSAC. Each skill detailed within the responses was tallied, categorized, and included in a frequency chart below (see Figure 2). Responses were grouped into seven different categories: (1) rapport-building, (2) trauma education and coping, (3) advocacy, (4) cultural competency, (5) family support, (6) identifying strengths & resiliency factors, and (7) understanding family dynamics. Examples of responses from these categories include: providing validation and building trust; educating families about trauma and utilizing elements of TF-CBT; interfacing with systems, empowering children, and advocacy; understanding of family dynamics and cultural competency; encouraging open communication within the family and engaging disengaged family members; providing parental support and addressing shame/guilt felt by family members.

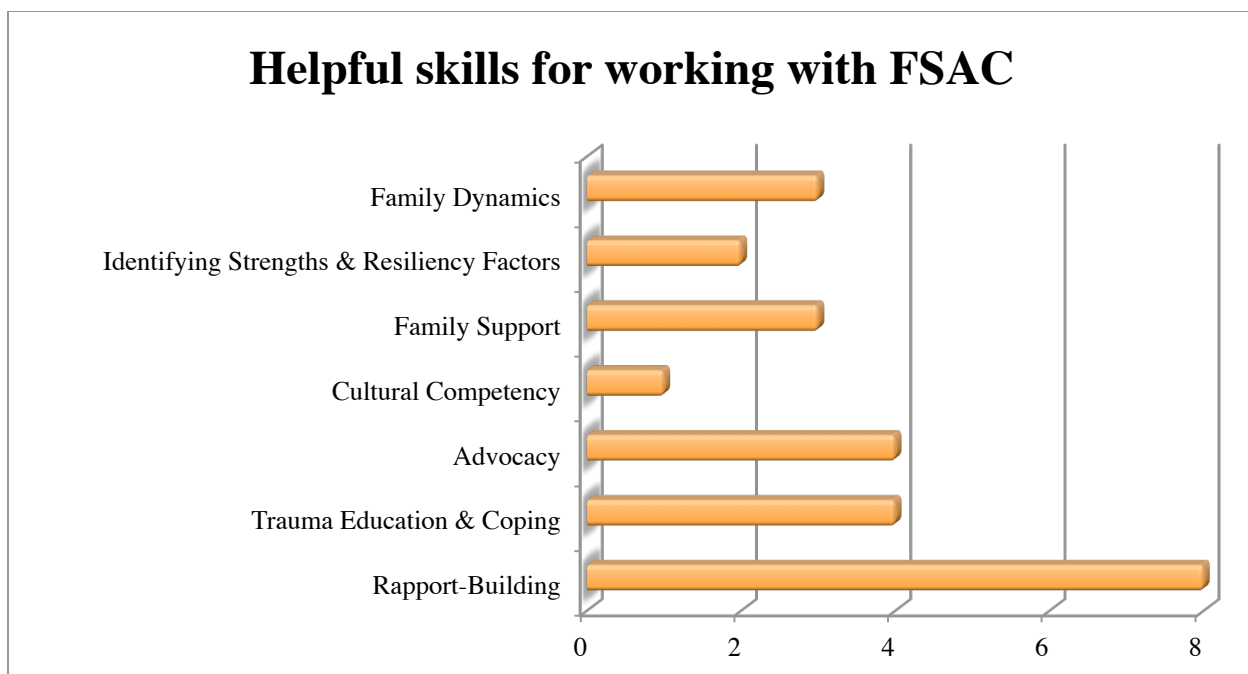


Figure 2. Helpful skills for working with FSAC.

The survey also gathered data from participants as it related to applying sociocultural perspectives into clinical work with FSAC. The survey asked respondents to list what specific key sociocultural factors are addressed or considered when working with FSAC. Various responses were given, of which the following were identified: cultural traditions, values, worldview, family religious and/or spiritual beliefs, intergenerational history of abuse and/or trauma, community stigma related to reporting, race, ethnicity, gender, sexual orientation, gender roles, disability, economic class, geographical location, immigration status, mental health history, mental health stigma and/or shame, substance use history, education, coping resources, access to services, and stigma of sexual abuse. These responses were grouped according to themes; see Table 2.

Table 2

Key sociocultural factors to consider with FSAC

Cultural traditions and worldview
 Family Spiritual Beliefs
 Values
 Intergenerational Abuse History
 Race, Ethnicity, Gender
 Sexual Orientation
 Disability
 Socioeconomic Status
 Geographic Location
 Immigration Status
 Access/familiarity to Services and Systems
 Psychoeducation
 Mental Health Stigma
 Stigma of Sexual Abuse

Seventeen participants stated they would benefit from additional training specific to working with FSAC; one survey participant responded they would not benefit from additional training. Many survey responses were given to the question, “What specific information would you like to see in your future training or continuing education in relation to FSAC?” For a general overview of responses provided, see Table 3 below. Suggestions for areas of future training included best practices for working with families, sociocultural considerations, basic interventions for fostering family support, increased engagement in treatment, trauma- focused psychoeducation for families, and family/systems model training. This project also sought information related to specific training received in the areas of post-traumatic growth, resiliency, sociocultural context, and empowerment. For each of these training areas, one participant indicated receiving training in these areas in relation to working with FSAC: post-traumatic growth, sociocultural context, and empowerment. Three survey participants reported receiving

training in resiliency as it relates to FSAC. Survey participants were also asked to provide recommendations for child sexual abuse training. The responses provided offered recommendations to research and/or utilize other programs (i.e., “Darkness to Light.”)

Table 3

Suggestions for Future Trainings for MHPs Working with FSAC

General interventions for supporting families

Parent education

Posttraumatic growth

Child development

Trauma education

How to work with family members who are critical/rejecting of the child

Updated information on impact of sociocultural factors on FSAC

Description of the Webinar

Informed by the comprehensive literature review and the needs assessment survey, the webinar was developed in the form of power point slides. A suggested script was included in the notes area to reflect the oral commentary accompanying each slide. A total of 34 slides were developed. The webinar presentation slides did not specify distinct sections, however, the five following phases guided the webinar structure: (a) Introduction, Purpose, and Education; (b) Impact of CSA on Families and Sociocultural Considerations; (c) Family Treatment: Strengthening Resources and Resiliency; (d) Presentation of Clinical Vignettes, and (e) Closing Remarks, Q&A (see Appendix F). The order of phases listed above reflects the order in which topics are presented and discussed in the webinar training. Information contained in these phases are listed below.

Webinar Outline

Phase 1: Introduction, purpose, and education. The initial phase of the FSAC module aims to orient the webinar participants to the purpose and rationale behind the training for the targeted population (FSAC). The rationale for the webinar is emphasized with a brief discussion of the lack of specialized training for working with FSAC, and gaps in clinical training programs, curricula, and extant literature related to CSA and FSAC. Given the likelihood that mental health professionals will come into contact with sexually abused individuals or family members of someone with a sex abuse history at some point in their career, the important role that MHPs have in guiding and supporting these individuals is profound. MHPs are often considered “first responders” to CSA disclosures and there are specific ethical and legal obligations MHPs have in serving protected populations such as children. The introductory nature of the webinar is presented and participants are informed of the estimated 30-minute length of the training.

The initial phase presents general information as it relates to CSA: statistics, prevalence rates, reporting issues, and barriers to disclosure. Dynamics of abuse and disclosure among families are also discussed to illuminate the intricacies of family dynamics as they relate to CSA and ongoing difficulties with reporting, disclosure, and obtaining accurate prevalence rates. Information related to the need for critical assessment when working with families is emphasized because children do not always self-disclose sexual abuse. Rather, family members including caregivers and siblings may hint at potential ongoing abuse, or may disclose that they have a history of CSA, which may bring new elements into treatment.

Phase 2: Impact of CSA on families and sociocultural considerations. Information presented in this phase emphasizes the utility and generalizability of knowledge regarding family

dynamics and responses to trauma. During this segment of the training, information is presented on the importance of integrating families into CSA treatment. Family involvement in treatment is a mediator of general mental health outcomes for children and caregiver mental health and functioning is often overlooked (Celano et al, 1996). With respect to families of sexually abused children, support from caregivers has been found to be more important than abuse-related factors in mediating the outcome for children following CSA (van Toledo & Seymour, 2013).

Information on potential offender profiles, and the unique relationship caregivers or family members often have with alleged perpetrators of child sexual abuse is discussed. Intrafamilial abuse dynamics and extrafamilial abuse behavior and characteristics associated with both types of abuse are also presented.

This second phase of the webinar training also includes discussion of the unique sociocultural implications that are intertwined with matters of childhood sexual abuse. This includes a presentation of the literature that addresses varying cultural values including, but not limited to: gender dynamics, sexual scripts, virginity, shame, status of women, harmony, and use of violence, as they relate to CSA. Additional information is presented on sociopolitical considerations such as safety, poverty, acculturation, language, perceptions of help-seeking behavior, perceptions of legal proceedings, and the financial, emotional, and interpersonal costs associated with reporting. Additionally, the emotional and behavioral impacts of CSA on family and caregivers are identified and discussed. Emotional reactions from caregivers may be anything from anger, despair, disbelief, or ambivalence (Celano et al., 1996 ; Regehr, 1990; van Toledo & Seymour, 2013). Parental stress may heighten which may impact confidence or perceived competence as a parent (van Toledo & Seymour, 2013). This portion of the webinar presents information from the literature related to emotional and psychological effects of the

parent or caregiver, as the impact may be mitigated by the relationship and involvement with the accused abuser (Somer & Szwarcberg, 2001; van Toledo & Seymour, 2013). Finally, the phenomenon of transgenerational trauma is addressed as a caregiver may have a personal history of CSA and thus, there may be additional considerations to conceptualize and treat the family as a unit. This phase of the webinar emphasizes a holistic conceptualization of the family and the need to consider culture and other dimensions of diversity in order to understand family functioning. Doing this from a strengths-based perspective is emphasized in order to avoid stereotyping or over-pathologizing cultural beliefs or practices.

Phase 3: Family treatments, strengthening resources & resiliency. The third phase of the FSAC webinar provides an overview and rationale for conceptualizing the abused child within a family context and provides information on existing family treatments and recommendations consistent with strengths-based treatments. The importance of astute assessment skills is discussed in relation to detecting and reporting abuse (pre and post-disclosure). Assessment considerations are identified and the need for integrative assessments is emphasized. Assessment is critical when seeing clients of any demographic (and when administering questionnaire(s) related to sexual abuse). Specific recommendations for assessment post-disclosure are provided which include using an initial family needs assessment, identifying coping strategies being utilized, and assessing the strengths of the family, as a preliminary effort to strengthen their available resources as they progress through treatment.

An abbreviated review of current family treatments is also presented, beginning with an overview of Trauma-Focused CBT (TF-CBT). The various elements and theories that are encapsulated within TF-CBT are identified, including cognitive therapy, behavioral therapy, family therapy, attachment theory, and developmental neurobiology. Family therapy and

attachment theory are emphasized for the relevance to working with FSAC. Further, a general overview of other treatments available for families of sexually abused children were presented, focusing on Family Systems approaches, and other group-based interventions (e.g., psychoeducation groups, support groups, etc.) that could be utilized as adjunctive treatments for FSAC. Families Moving Forward, a curriculum for families of children with Fetal Alcohol Spectrum Disorder, was selected as an existing intervention program for which FSAC treatment recommendations may also apply. FMFs' focus on building support for families and caregivers, educating parents on their child's symptoms, skills training, and emphasis on family growth, recovery, and restoration of hope and optimism make it particularly relevant to treatment of FSAC. Treatment recommendations grounded in strengths-based perspectives are highlighted; families and caregivers are viewed as potential allies in reducing risk, promoting well-being and creating healthy futures for their children. Specific recommendations include: (a) increasing families' coping ability; (b) encouraging safety for all and establishing healthy boundaries; (c) managing and working through feelings of guilt, denial, anger, and self-pity; and (d) provision of parenting assistance (managing a child's possibly new presentation of mood and behavior).

Phase 4: Presentation of clinical vignettes. The preceding phase includes discussion of treatment suggestions and areas of focus for working with FSAC. The fourth phase of the webinar provides an opportunity to apply this information and invites participants to read along two clinical case vignettes. The two vignettes illustrate two presentations of caregivers seeking therapy. The first fictional vignette focuses on Mrs. Moreno, a 45-year-old Latina female who was awarded legal guardianship of a 10-year-old child, Audrey. The vignette identifies that Audrey regularly visits her social worker for general follow-up. In this vignette, Mrs. Moreno is seeking individual therapy after recently being informed that Audrey was sexually abused as a

child (prior to her foster care placement with Mrs. Moreno). Mrs. Moreno's presenting problems include report of sadness, shock, worry, guilt and hopelessness she will not be able to "fix" Audrey. Mrs. Moreno discloses for the first time that she was also sexually abused as a child. The second clinical vignette presents Mrs. Robertson, a fictional individual who has recently divorced and moved into her brother's home. Her presenting problem includes a report of anxiety, shame, guilt, and confusion. Mrs. Robertson discloses concerning behaviors and recent onset of symptoms from her daughter to include early warning signs of CSA that allude to her brother as the abuser. Mrs. Robertson's reaction includes guilt, fear, and feeling confused on whether to proceed with pressing criminal charges against her brother. These fictional representations of caregivers are meant to invite the webinar participants to conceptualize the individual, and present treatment recommendations and themes to focus on during treatment. After the webinar presents each vignette, it is followed up with reflection questions for participants to think through and discuss.

Phase 5: Closing remarks, Q&A. Following the discussion of the last vignette, closing remarks are made and key points are reviewed. An abbreviated list of online resources is presented, selected references are listed, and the final portion of the webinar includes space for Q&A in the case of live streaming.

FSAC Webinar Evaluation Survey

Evaluator description. One evaluator was recruited to complete the initial planned Webinar Evaluation. Responses were reviewed to inform the identification of strengths and areas for improvement. The webinar evaluator indicated they have obtained a doctorate in clinical psychology, maintain an active license as a psychologist, and currently work as a program coordinator. They indicated having 14 years of experience working in the mental health

field; the evaluator reported having 14 years of experience working with families of sexually abused children. The evaluator indicated having experience working in both community mental health and private practice.

Evaluation feedback. The evaluator was asked to review the webinar curriculum in its entirety and complete a brief survey for webinar feedback. See Tables 4-6 for truncated webinar evaluation responses and suggestions. Feedback was solicited for the degree of usefulness of the webinar, whether the webinar was informative, if the webinar included focused and specialized training, and feedback related to the perceived beneficial nature and applicability of the webinar. Possible item responses ranged from “strongly agree” to “strongly disagree” on a 5-point likert scale. The evaluator indicated the training is most useful for early career MHPs more so than mid to late career MHPs. The evaluator strongly agreed that the training is informative. They strongly agreed that the webinar included focused and specialized training necessary for preparing mental health professionals to work with FSAC. The evaluator also agreed that the webinar increased MHPs appreciation of the complex nature of FSAC.

In addition, the evaluator was asked to provide their thoughts on what ways the webinar training specifically contributes to MHPs knowledge, understanding, and/or readiness to treat families of sexually abused children. There was no text or character limit in the response field; the evaluator stated, “I think it is incredibly important to see the child as embedded within the family system and the need for a family systems approach to fully understand how to treat a minor.” The evaluator was also asked to provide an open response to the question, “In what ways do you think the strengths-based perspective is beneficial in informing [MHPs] current or future treatment of [FSAC]?” To this question the evaluator responded, “A strengths-based approach assists both client and clinician in maintaining hope and a balanced view of the client.

It has been very helpful for me in reducing burnout.” When asked to discuss how applicable is the presentation of sociocultural issues surrounding FSAC to MHPs current or future treatment of FSAC, the evaluator stated, “Sexual abuse in particular carries significant cultural, religious, and social bias due to the sexual nature of the assault. Therefore it is essential for clinicians to consider these factors when working with survivors of CSA.”

The evaluator was asked to provide an open response about what they found most effective from the webinar training. They responded, “The discussion about how systemic factors can influence the presentation of CSA.” In response to inquiry regarding their overall impressions about the training resource, the evaluator stated, “I think it provides a guide for early-level professionals to consider the myriad of factors associated with CSA. It also reflects components of the NCTSN trauma competencies.” The evaluator provided suggestions for modification and/or inclusion stating, “I think it would be helpful to focus more on how involvement with police and DCFS might effect disclosure and seeking treatment as this has been a major component of my previous work with children.” Lastly, the evaluator’s feedback was solicited regarding the value of presenting the webinar as a larger series that would also include segments on sexually exploited minors and perpetrators of child sexual abuse. The evaluator commented, “I do not think it would be valuable to focus on [all sub-populations] in the same webinar series. I cannot see the likelihood that a clinician might be working with both populations, and the competencies are so different with each [sub-population].”

Table 4

Webinar Evaluation Results

Webinar is useful for early-career MHPs
 Less useful for late-career MHPs
 Webinar is informative
 Webinar included focused and specialized training to prepare MHPs to work with FSAC
 Webinar increased appreciation of the complex nature of FSAC

Table 5

Webinar Content Feedback

Webinar emphasized the importance in seeing the abused child as embedded in the family system; importance of family systems approach
 A strengths-based approach helps client and therapist maintain hope; prevents clinician burnout
 It is essential to consider sociocultural factors when working with CSA
 Discussion of how systemic factors influence CSA was effective
 Webinar reflects components of NCTSN trauma competencies

Table 6

Suggested Webinar Changes

Focus more on how involvement with DCFS and law enforcement affects disclosure
 Longer, broader webinar including other sub-populations (i.e., perpetrators, sexually exploited minors) would not be valuable; decreased likelihood of working with all populations.
 Different competencies associated with each CSA sub-population; an expanded webinar was not deemed as valuable.

Chapter 5: Discussion

The purpose of the current project was to develop a webinar to support the training of mental health professionals to work competently with the widespread phenomenon of childhood sexual abuse. More specifically, this project focused on the needs of families of sexually abused children to create an introductory webinar training for mental health professions that presents information relevant to working with families of sexually abused children, with particular attention to sociocultural and strengths-based perspectives. A review of the literature suggests that the scope of CSA is broad, however, there is much more to be known about the unique challenges families face as they support their affected child. Additionally, the literature generally focuses on pathology of CSA; both the short-term and long-term effects. This project further sought to integrate strength-based considerations and treatment recommendations to bolster resources, reconstruct meaning, and focus on thriving after experiencing trauma such as CSA. Given the different stressors and reactions to stress that individuals and families experience, this project aimed to broaden the scope of current research that often disregards nuances of family experiences or the unique sociocultural components that affect how the effects of CSA reverberate in a family or the community. CSA is a widespread problem and mental health professionals' legal and ethical duties of mandated reporting increase the need for specialized CSA training. Further, training programs appear to address mental health needs and challenges of those who have experience child sexual abuse in a homogenous manner, without sufficient attention to factors that contribute to the variability in experiences and outcomes. This project primarily focused on addressing the treatment needs of nonoffending family members; however, this has potential implications for future studies, including expanding upon areas of the

family experience that were not touched upon in this webinar (i.e., family needs when there is disclosure of intrafamilial sexual abuse). Suggestions for future research will be discussed.

Overview of Results

Twenty-one participants, including master's level and doctoral level mental health clinicians, completed the training needs survey. Results of the survey indicated that there were perceived gaps in training related to working with families of sexually abused children. MHPs who completed the survey indicated feeling unprepared for working with FSAC. Several survey participants identified skills they deemed as helpful when working with FSAC; these were broken down into the following categories: rapport-building (i.e., validating, addressing shame and/or guilt nonjudgmentally), providing education (i.e., providing resources, psychoeducation on responses to trauma), understanding family dynamics (i.e., engaging disengaged family members, fostering open-communication), and incorporating resiliency-building factors into treatment (i.e., advocacy, challenging distorted thinking). Survey respondents identified sociocultural factors that may be relevant to working with FSAC such as identifying cultural traditions worldviews, considering intergenerational abuse history, access to services, and mental health stigma. These initial survey results helped bolster the impetus to develop a webinar training targeted for MHPs working with families of sexually abused children.

In order to develop the webinar aimed at increasing knowledge improving clinical and cultural competency related to treating families of sexually abused children from a strength-based sociocultural perspective, a thorough and comprehensive review of the literature, review of existing resources, and review of data from the training needs survey was completed. An introductory training that was not to exceed 30 minutes was created, with a focus on the treatment needs of nonoffending family members of sexually abused children. A PowerPoint

presentation with an accompanying script was developed. The webinar included learning objectives related to increasing understanding of an overlooked population (i.e., FSAC) and a discussion of the rationale for specialized training was included.

The webinar also discussed the focus on psychopathology rather than on posttraumatic growth or resiliency factors associated with CSA survivors and families of sexually abused children. General information related to CSA was provided; definitions, prevalence rates, reporting difficulties, and factors contributing to delayed disclosure were identified. Family factors associated with CSA were noted and intrafamilial child sexual abuse and extrafamilial child sexual abuse were described. Sociocultural and sociopolitical factors as they relate to CSA were identified and discussed within the webinar content; potential sources of cultural supports and strengths were identified. Obtaining a nuanced understanding of culture as it pertains specifically to an individual or family was highly emphasized in order to avoid homogenous conceptualizations of culture. The effect of CSA on families was discussed, with an emphasis on the stress contagion non-offending family members may experience. Current treatments for family members were identified including Trauma-Focused CBT (TF-CBT), family systems approaches, Families Moving Forward, and other group-based adjunctive treatments available to family members. Two case vignettes were created in order to encourage participation and exercise of learned concepts. Reflection questions were developed for each of the two vignettes and take-away points were identified to conclude the webinar training. An abbreviated list of online resources and selected references were made available. Lastly, a question and answer portion was dedicated at the end of the webinar for final questions or remarks from participants.

Once the webinar content was created, it was sent to an evaluator to review the relevance, usefulness, and overall benefit of the webinar content. Purposeful sampling was utilized to

obtain an evaluator with the required amount of experience working with families of sexually abused children. The evaluator rated the webinar as most useful for early-career MHPs, informative, focused and specialized, was beneficial due to the strengths-based approach and family systems approach, and appeared to appreciate the complex nature of families of sexually abused children. Suggestions for webinar modifications included feedback on including more information on how involvement with law enforcement and child services agencies might affect disclosure and treatment-seeking.

Limitations and Future Directions

There are several limitations of the current project that must be considered. First, it is recommended that the objectives of the webinar be clarified with realistic goals in the context of types of attendees, length of time for the training, and scope of content. Keeping the objectives in mind, the projected duration of the webinar and how it is presented could be modified. Although the researcher proposed and developed the current webinar as introductory in nature, a 30 minute duration was not feasible to present the material included in the curriculum. As a recommendation for future development, structuring the webinar as an ongoing training tool may be most beneficial way to present complex ideas and practice scenarios to clinicians at all levels of experience in the field. CSA content is rich and nuanced; as an ongoing webinar series, developers have the option of presenting a different topic per session as it relates to CSA. By doing this, information may be more easily digested by clinicians and it may be presented in shorter sessions. Results from the webinar evaluation indicated that the webinar is best suited for early-career clinicians. By initiating an ongoing webinar tool tailored to CSA topics, early, mid, and late-career clinicians may be able to benefit from topics presented. Additional CSA related topics to be presented in future webinars/modules would be to include a focus on the particular

experience of non-offending fathers. The two vignettes included in the current webinar curriculum present hypothetical clinical cases, however, both examples are females and mothers. It is recommended that future webinars be more inclusive to the experience of fathers and to present a clinical vignette of a father of a child who has disclosed CSA. Additionally, it is recommended that there be more discussion on the experience of siblings, possibly enhanced by a clinical vignette with tailored discussion questions. Other recommended CSA topics to be included in future modules include: exploring possible countertransference between client and therapist as it relates to CSA and expanding the focus of stress contagion to include the experience of the therapist.

As a way to make the webinar training more enriching, it is recommended that there be more specific interventions or tailored recommendations for webinar participants to be able to use when working with clients. An example of this would be to perhaps discuss or present ways to intentionally establish and build rapport with families, due to this being a critical factor at the outset of therapy.

Another limitation of the current project is related to methodological concerns. Within the initial MHP needs survey, data collected was not specific to FSAC, but rather addressed issues pertaining to various sub-populations of CSA (i.e., sexually exploited minors, perpetrators of child sexual abuse). Additionally, the project's sample population for the MHP Training Needs Survey was narrow in scope due to use of convenience sampling methods. Initial recruitment efforts began by contacting the researchers' affiliated university to distribute the survey widely amongst faculty and students. Further, clinical training sites that maintain training contracts with the university were contacted for survey recruitment. This list of clinical training sites was obtained from the Director of Clinical Training through the university. Convenience

sampling also included emails to APA-accredited universities and professional school training programs as well as current and past clinical training sites and other personal and professional contacts that meet the survey participant requirements. Recruitment efforts were also narrow in scope with obtaining a webinar evaluator. Purposeful sampling was utilized and, after multiple potential evaluators declined, an alumna of the university's doctoral program was identified and recruited as the webinar evaluator. In addition, the original inclusion criteria was challenging to meet which resulted in the required years of experience being reduced from 20 years to 14 years. Future research would benefit from having multiple MHPs evaluating the webinar content.

These methodological choices pose several limitations. First, the training needs survey does not reflect the entire population of mental health professionals. The convenience sample was influenced by a narrow geographic location of mental health professionals (i.e., Southern California) and contained mental health professionals available in the researcher's educational and professional networks. Additionally, the sample size gathered for the training needs survey was relatively small ($N = 21$). This choice in methodology was made due to limited resources and time available to the researcher(s). Future research would benefit from a larger sample size and recruitment efforts made outside of the networks connected to the host doctoral program. By expanding the sample size and recruitment efforts, more meaningful data can be gained about the needs of mental health professionals more broadly and outside of the geographic region of Southern California. Mental health professionals' needs as it relates to child sexual abuse and treating families of sexually abused children may vary if data were to be obtained from other educational programs and geographic locations.

Another limitation of the current project was its focus on non-offending caregivers. While the literature demonstrates a gap in addressing the needs of non-offending caregivers,

there may be settings where a perpetrator of child sexual abuse is also a family member. Future research would benefit from expanding on the characteristics, experiences, and treatment needs of these individuals. Another area is the complex phenomena of transgenerational trauma, and while it was mentioned within the context of the literature review for the current project, the experiences of family members and caregivers who they themselves have experienced trauma, is a topic that mental health professionals may benefit from receiving specialized training in. There are a unique set of personal circumstances and family dynamics that occur when this is the case; future trainings would benefit by elaborating on this phenomenon and discussing additional factors to integrate into treatment. Siblings are integral members of the family system and are vital to shaping the family environment (Crabtree, Wilson, & McElvaney, 2018). Disclosure of CSA carries the potential to disrupt the lives of siblings, yet the needs of nonabused siblings have been largely overlooked. Future revisions of the webinar would benefit from an inclusion of sibling perspectives of CSA. The impact of sexual abuse affects siblings and is compounded by other family members' distress. Additionally, the evaluator identified a limitation of the webinar content; it was suggested that the webinar include a discussion of how police involvement or Department of Children and Family Services (DCFS) involvement affects disclosure and treatment seeking. This recommendation would be an important inclusion for future revisions of the webinar and areas of focus in CSA literature.

Given the limitations discussed above, the following recommendations have been identified for potential next steps in the development of the webinar:

Recommendation #1: Re-define learning objectives of webinar. Develop a webinar that is an ongoing training tool for MHPs with a different CSA related topic presented during each module.

Recommendation #2: Include more tailored interventions or “takeaway points” within each module so that webinar participants have a tangible tool to use with clients.

Recommendation #3: Add more content areas to webinar. Suggested topic areas are: the experience of non-offending fathers of CSA; DCFS involvement and the effect on rapport and/or treatment environment; siblings of sexually abused children; countertransference between client and therapist as it relates to CSA; and discussing stress contagion as it relates to therapists treatment of sexually abused children and/or FSAC.

Recommendation #4: Develop a MHP needs survey tailored to treatment of FSAC.

Recommendation #5: Obtain a larger sample size for MHP needs survey.

Recommendation #6: Recruit outside of networks made available through connections with the host doctoral program; recruit outside of the geographic region of Southern California.

Recommendation #7: Expand upon the characteristics, experiences, and treatment needs of nonabused siblings.

Recommendation #8: Elaborate on the phenomenon of transgenerational trauma and discuss additional factors to integrate into treatment.

Recommendation #9: Discuss how involvement of outside agencies (i.e., law enforcement, DCFS) affects disclosure and treatment seeking.

Recommendation #10: Identify and discuss the effects of CSA on siblings and how they can be supported.

Implications for Theory and Practice

Given the incidence of CSA and the development of emotional and behavioral difficulties for victims, Kenny and Abreu (2015) assert that all mental health professionals should receive training in the identification and dynamics of CSA. This study has broadened the scope of

current training by emphasizing the importance of family systems, sociocultural, and strengths-based approaches in the treatment of child sexual abuse. Important concepts emphasized in the literature related to CSA training were identified and discussed, including reporting procedures, relationship between victim and abuser, disclosure patterns, and empirically based treatments (Kenny & Abreu, 2015). The literature review and survey results from the current project indicated lower availability of information on family members of sexually abused children and the lack of specialized training for mental health professionals treating this population. While cultural competence is a growing interest and area of research and focus, sociocultural and sociopolitical factors as they relate to CSA are more difficult to find in the literature. Kenny and Abreu (2015) recommend that CSA training should examine individuals' values and beliefs as well as their own experiences with CSA. This project sought to illuminate and integrate sociocultural factors as they relate to CSA in general, and how they impact families of sexually abused children. The amount of literature and research available on how sociocultural factors affect and are interrelated with CSA matters is limited; continued efforts to expand upon these areas and identify new and developing trends in CSA would be beneficial. Furthermore, the treatment considerations discussed in the literature review and included in the webinar content are strengths-based; the focus is on identifying resources, developing strengths, and encouraging growth and resiliency for families affected by CSA. Research has encouraged the field of family therapy to operate from a strength-based rather than a deficit model, by collaboratively working with families to learn new ways of coping with traumatic stress in imaginative and creative ways (Hunter, 2006). These efforts support integrating aspects of culture into the practice of psychotherapy and harnessing individual, family-based, and cultural sources of well-being and pride into strengths-based interventions.

Online resources have the potential for far greater reach than face-to-face trainings; this project sought to create an online webinar training that would eventually be available to a large audience and that would be accessible any time of day. Creating an introductory webinar resource for training MHPs working with FSAC is a preliminary step towards increasing the educational resources available online for this underserved population, something that is discussed at length in the literature as areas for future study (van Toledo & Seymour, 2013). By developing a webinar training, dissemination to mental health professionals will be an important next step.

In conclusion, the findings of the current project demonstrate the importance of research that can increase a more holistic and systemic understanding of factors that impact the experience of child sexual abuse within families. This includes attention to sociocultural and sociopolitical factors that affect the presentation of child sexual abuse and how families and other networks are affected by such events. Family dynamics are rich and complex. Expanding training opportunities for mental health professionals to incorporate these dynamics is important, particularly as applied to child sexual abuse. Psychological services would greatly benefit from further research, as well as resource or training development that substantially integrates the experiences families of sexually abused children face.

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APPENDIX A

Recruitment Form

Hello [insert name of mental health professional],

You are invited to participate in a research study conducted by Heidi Arredondo, M.A., and supervised by Shelly Harrell, Ph.D. at Pepperdine University. My dissertation project, titled, **“Development of an Introductory Webinar Training for Mental Health Professionals Working with Families of Sexually Abused Children: A Strength-based Sociocultural Perspective”** needs your assistance.

I am currently conducting an online study to assess the level of exposure and specific training related to treating families of sexually abused children. I am interested in developing an introductory webinar training for mental health professionals treating this specific sub-population related to child sexual abuse and would greatly appreciate your input.

In order to participate in this survey, you must be:

- 1) a **Master’s or Doctoral level** mental health professional
- 2) a mental health professional in **the United States**, and
- 3) a **licensed** mental health professional.

The survey will take no more than 10 minutes and participation is completely voluntary and your responses will be de-identified. Additionally, the researcher kindly request that you distribute this email, with survey link, to other mental health professionals and networks. Your assistance is greatly appreciated.

If you would like to participate, please answer the questions in the survey linked below [insert link to survey]. If you have any questions about this study, please send an email to [insert email address here].

Thank you,

Heidi Arredondo, M.A.

APPENDIX B

Informed Consent to Participate

Pepperdine University
Graduate School of Education and Psychology

Informed Consent for Participation in Research Activities
--

Development of an Introductory Webinar Training for Mental Health Professionals Working with Families of Sexually Abused Children: A Strengths-Based Sociocultural Perspective.

You are invited to participate in a research study conducted by Heidi Arredondo M.A., and Shelly Harrell, Ph.D. at Pepperdine University because you are a mental health professional working in the United States. Please read the information about the study that is outlined below and decide whether you would like to participate. Your participation in the study is voluntary. If you have any questions prior to consenting to participate, please send an email to [insert email address here]. If you decide to participate, please check yes on the following question and proceed with the survey.

PURPOSE OF THE STUDY

The overall purpose of this study is to develop an introductory webinar training for mental health professionals (MHPs) that focuses on the introductory mental health treatment of child sexual abuse with respect to families of sexually abused children in the United States.

STUDY PROCEDURES

If you agree to participate in this study, you will be asked to complete a confidential online survey that will take approximately 10 minutes to complete. The survey questions include a series of questions about your credentials and/or licensure, experience working with the specified population, and quality of training you have received with this population. In addition, you will also be asked to provide open-ended feedback on areas or topics you deem useful for training MHPs who work with populations affected by childhood sexual abuse.

After completion of the survey, the researcher will review data for content and suggestions will be considered for inclusion in the creation of the webinar. Following the completion of a comprehensive literature search, review of existing resources and review of MHPs training needs survey results, the webinar training resource will be created. In order to gather preliminary data about the usefulness and relevance of the webinar training, a purposeful sample will be utilized to recruit one mental health professional with expertise pertaining to families of sexually abused children (FSAC). Following expert review of the webinar curriculum and completion of the webinar training feedback/evaluation, data will be collected and organized into a list of future directions for improving the webinar training resource.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study include feelings of fatigue, boredom, and discomfort as a result of the nature of the questions asked pertaining to clinical experiences and/or population served. It should be noted that the risks involved in the

present study are not viewed as greater than that experienced during the course of ordinary discussion of personal life experiences. Your involvement in the study and completion of the study is strictly voluntary. You may choose to leave responses blank or discontinue the survey at any point in time with no adverse consequences.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are several anticipated benefits to society and the mental health field, which include: acknowledgement of contribution to the mental health field and improved mental health training/education of CSA for MHPs. More generally, the study may also benefit psychological literature and society because it may contribute to greater understanding of childhood sexual abuse and trauma, strengths-based conceptualization, and sociocultural diversity factors. Additionally, by outlining a webinar training curriculum the researcher hopes that there may be greater interest in specialized mental health training for professionals and greater mental health care provided to these interrelated sub-populations (i.e., families of sexually abused children).

PAYMENT/COMPENSATION FOR PARTICIPATION

There will be no payment/compensation for participation in the 10 minute survey. Mental health professionals with expertise pertaining to the identified sub-populations who have been purposefully recruited and who have agreed to provide an evaluation of the webinar training curriculum will be compensated with a \$20 electronic gift card.

CONFIDENTIALITY

The records collected for this study will be confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected from you. Please keep confidentiality in mind when providing open-ended feedback within the survey. Please avoid using names or revealing any identifying patient information. If you choose to reveal information regarding clinical work with a patient, please use a pseudonym and change any identifying information (e.g., treatment facility, geographic location, etc.) Examples of the types of issues that would require researchers to break confidentiality are any instances of child abuse, elder adult abuse and dependent adult abuse. Pepperdine University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The identity of participants completing the survey will not be obtained, as the survey will not ask any identifying information. Your mental health employment history and clinical experience may be included as part of your response to survey questions. Data gathered from the survey will be coded and de-identified so that private information will be kept separate from information collected. The data will be stored for a minimum of three years.

SUSPECTED NEGLECT OR ABUSE OF CHILDREN

Under California law, the researcher(s) who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, including child pornography, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or only completing the survey items you feel comfortable responding to.

INVESTIGATOR'S CONTACT INFORMATION

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Heidi Arredondo and Shelly Harrell, Ph.D. at [insert email addresses] should you have any additional questions or concerns about this research study.

RIGHTS OF RESEARCH PARTICIPANT

If you have questions, concerns or complaints about your rights as a research participant or research in general, please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive, Suite 500, Los Angeles, CA 90045, (310) 568-5753 or at gpsirb@Pepperdine.edu.

By checking the box below, you acknowledge that you have read the information provided above, you have been given the opportunity to ask questions or address concerns, and you agree to participate in this study.

APPENDIX C

Training Needs Survey

1. I have read the information related to the present study and agree to participate in this voluntary questionnaire. I understand that I may elect to discontinue the survey with no penalty.
 - a. Yes
 - b. No
2. What is your current job title?
[Open text response field]
3. Are you currently licensed?
 - a. Yes
 - b. No
4. What mental health license do you have? (e.g., LMFT, LCSW, Psychologist, etc)
[Open text response field]
5. How many years of experience do you have in the mental health field?
[Open text response field]
6. Are you currently working or have you previously worked with families of sexually abused children?
 - a. Yes
 - b. No
7. How many years of clinical experience do you have working with families of sexually abused children?
[open text response field]
8. What skills have you found most helpful in working with families of sexually abused children?
[Open text response field]
9. Have you received any specialized training working with families of sexually abused children? If so, please specify:
[Open text response field]
10. Was the training you received adequate in preparing you to work with families of sexually abused children?
 - a. Yes
 - b. No
11. Have you noticed any gaps in your training versus the actual skills needed in working with families of sexually abused children?
 - a. Yes
 - b. No

12. What are some of the key sociocultural factors to address or consider in working with families of sexually abused children?
[Open text response field]
13. Do you believe you would benefit from additional training in working with families of sexually abused children?
- Yes
 - No
14. What specific information would you like to see in your future training or continuing education in relation to families of sexually abused children?
[Open text response field]
15. Have you received training in any of the following areas in relation to working with families of sexually abused children? Please specify what topics were discussed.
- Thriving in the face of adversity
 - Post-Traumatic Growth
 - Resiliency
 - Sociocultural context
 - Well-Being
 - Empowerment
 - Positive Psychology
 - Other (please specify)
16. What other recommendations do you have for trainings on child sexual abuse?
[Open text response field]

APPENDIX D

Invitation to Webinar Training Evaluation Survey

Hello [],

You are invited to participate in a research study conducted by Arredondo, M.A., and supervised by Shelly Harrell, Ph.D. at Pepperdine University. The dissertation project titled, “**Development of an Introductory Webinar Training for Mental Health Professionals Working with Families of Sexually Abused Children: A Strength-based Sociocultural Perspective**” needs your assistance. The project is seeking one expert mental health professional to evaluate the webinar training curriculum for the usefulness, effectiveness, and relevance of its content. The evaluation consists of reviewing the webinar curriculum (up to 1 hour) and subsequently completing an evaluation survey (approximately 10-15 minutes). The evaluation uses a 5-point Likert scale to rate how strongly you disagree or strongly agree with the quality and content of the proposed curriculum and will also include open-ended questions. The evaluator will receive a \$20 gift certificate to Starbucks as compensation for their time.

In order to evaluate the curriculum for the training as an expert mental health professional you must qualify as any one of the following:

- licensed mental health professional with **over 20 years of experience** with sexually abused children or families of sexually abused children,
- **director (or previous director) of a program** that focuses on treatment of sexually abused children or families of sexually abused children,
- must have **published** in relation to sexually abused children or families of sexually abused children **within the past 10 years**.

We would greatly appreciate your input.

If you would like to participate, please review the webinar training curriculum in the PowerPoint document attached to this email and answer the questions in the survey document attached. If you have any questions about this study, please send an email to [insert email address].

If you are unable or unwilling to participate, please consider forwarding and distributing this invitation to other licensed mental health professionals that may hold such expertise in either of these populations.

Thank you,

Heidi Arredondo, M.A.

APPENDIX E

FSAC Webinar Evaluation Survey

1. This training on CSA was **informative**.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

2. This training is **useful** for:

- a. early career MHPs

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

- b. mid-career MHPs

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

- c. late-career MHPs

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

3. This webinar includes **focused and specialized** training necessary for preparing mental health professionals to work with families of sexually abused children.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

4. In what ways did this training specifically contribute to your knowledge, understanding, and/or readiness to treat **families of sexually abused children**?

[Open text response field]

5. In what ways do you think the strengths-based perspective is beneficial in informing mental health professionals' current/future treatment of families of sexually abused children?

[Open text response field]

6. How applicable is the presentation of **sociocultural and sociopolitical issues** surrounding CSA in this training to your current/future treatment of **families of sexually abused children**?

[Open text response field]

7. This training increased my appreciation for the **complex** nature of CSA.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

8. What did you find **most effective** about this training resource?

[Open text response field]

9. What are your **overall impressions** about this training resource for MHPs?

[Open text response field]

10. Please provide any **suggestions** for modification and/or inclusion that you think this training resource requires.

[Open text response field]

11. This training resource on families of sexually abused children was designed as part of a larger training webinar series to include segments focused on the related populations of sexually exploited minors and perpetrators of child sexual abuse. Please comment on your impressions about the **value** of presenting these three populations **together** in the understanding of different facets of child sexual abuse.

[Open text response field]

APPENDIX F

Webinar Training for FSAC

Working with families of sexually abused children

An introductory webinar for mental health professionals with strength-based and sociocultural perspectives



Learning Objectives

- Obtain a fuller understanding of child sexual abuse (CSA) matters including definitions, disclosures, prevalence rates, and reporting issues
 - Learn about family dynamics as they relate to CSA
 - Identify sociocultural and sociopolitical factors as they relate to CSA, and more specifically, families of sexually abused children (FSAC)
-

Learning Objectives (continued)

- Develop increased understanding of family treatment needs
 - Identify current family-based trauma treatments
 - Learn how to identify strengths and resiliency factors among families affected by traumatic experiences
 - Identify sociocultural factors as family strengths during initial assessment and incorporate these elements into treatment plans and interventions
-

Professional Training

- Need for *specialized* training
 - Gaps in clinical training programs and curriculum
 - Lack of continuing education
 - Gaps in literature
 - Trauma training and literature is more focused on the psychopathology, need for more strength-based training
-

Mental Health Professionals (MHPs) and CSA

- Why is this training geared only towards mental health professionals?
 - Highly involved in CSA incidents
 - Considered “first responders”
 - Ethical and legal obligations
 - Opportune position to provide treatment and decrease the negative effects associated with CSA
-
-

Specialized Training

- Despite a high degree of involvement in CSA matters, there is a gap in training for MHPs
 - Lack of training in doctoral/master's level programs
 - Lack of training that is for sub-populations affected by child sexual abuse (i.e., families of sexually abused children)
 - Lack of strength-based informed treatment
-

CSA Definitions

- Definitions of child sexual abuse vary widely
- American Psychological Association (APA) definition of sexual abuse is “unwanted sexual activity, with perpetrators using force, making threats, or taking advantage of victims not able to give consent.”
- Rape, Abuse & Incest National Network (RAINN) definition: child sexual abuse is a form of child abuse that includes sexual activity with a minor.
 - Does not need to include physical contact between perpetrator and child

Prevalence Rates

- Widespread problem
 - 1 in 5 girls; 1 in 20 boys (National Center for Victims of Crime)
- However, rates are highly inconsistent
- Different reporting sources provide different rates
- Inconsistent and/or rigid definitions
- As a result of inconsistent criteria, definitions, reporting sources, there is a highly invalid representation of the phenomenon

Hunter, 2006; Lowe et al., 2007

Delayed Disclosure

- Self-report of CSA is rare
- Disclosures of CSA are often delayed or never reported
- Likely revealed through other methods
 - Witnessing “suspicious” behavior
 - Signs of physical trauma
 - Accidental reporting by children
 - Unexplained somatic complaints
- Mothers and peers were the most common recipients of disclosure

Malloy, Brubacher, & Lamb, 2013; Fontes, 2010

Delayed Disclosure

- What contributes to delayed disclosures?
- “Grooming” behaviors
- Age and sex differences
 - Males, more so than females, are found to delay disclosure of CSA well into adulthood
 - Young age likely leads to longer delays in disclosure
- Family dynamics
- Cultural values/beliefs that discourage disclosure directly or indirectly

Easton, 2013; Hunter, 2006; Sjöberg & Lindblad, 2002

Correlates of Abuse

- Family factors correlated with abuse victimization and/or perpetration
 - Less cohesive families
 - More problems coping with stress
 - More socially isolated families
 - High conflict families
 - Rigid values held within family unit
 - Insecure personal attachment

Alaggia & Kirshenbaum, 2005

Intrafamilial CSA

- Up to one-third of child sexual abuse is perpetrated by family members
- Of intrafamilial cases, fathers and step-fathers are the most common type of relative
- Clinical explanations of intrafamilial child sexual abuse (ICSA) focus on family structure and family member dynamics as key contributing factors
- May significantly impact disclosure of CSA

Seto et al., 2015

Cultural Values

- No culture is defined solely by one value, nor is any particular value held by one cultural group
 - Values present differently and are weighted differently across families and cultures
 - Values may affect attitudes, beliefs, and ultimately, disclosure of CSA
 - MHPs are to include cultural beliefs in case conceptualizations as a way to understand an individual's local, social world
-

Other Considerations

- Lower prevalence rates of CSA among ethnic minority groups
 - More attributed to barriers to disclosure
 - Influence of sociocultural factors and/or beliefs
 - Shame, taboos, virginity, sexual scripts, etc.
 - Powerlessness
 - Patriarchy
-

Values

- ▣ Shame
- ▣ Taboos
- ▣ Modesty
- ▣ Sexual Scripts
- ▣ Virginity
- ▣ Status of Women
- ▣ Honor
- ▣ Respect
- ▣ Patriarchy

Choi et al., 2015; Fontes & Plummer, 2010

Cultural Supports and Strengths

- ▣ Many protective factors are embedded into cultural values
 - ▣ Strong mother-child relationships
 - ▣ Intolerance of adult sexual practices with children
 - ▣ High value of women and children
 - ▣ Extended family supervision of children
 - ▣ Close relationships
 - ▣ Open discussion of sexuality
 - ▣ Social intolerance of abusive behavior

Fontes & Plummer, 2010

Sociopolitical Considerations

- Safety
- Poverty
- Community resources
 - Advocacy
 - Mental Health care
 - Medical care
 - Education
- Legal action
- Child custody risks

Ramírez, Pinzón-Rondón & Botero, 2011; Angelides, 2004; Morris, 2009

Effects of CSA on the Family

- Family structure
 - Intrafamilial abuse
 - Non-offending parents and caregivers
- Different effects on
 - Child

Stress Contagion

- ▣ Parents/caregivers question their ability to adequately serve as a parent
- ▣ Responses
 - ▣ Self-doubt
 - ▣ Shame
 - ▣ Guilt
 - ▣ Withdrawal
 - ▣ Overprotectiveness
 - ▣ Preoccupation
 - ▣ Anxiety and/or depression

National Traumatic Stress Network

Strengthening Family Resources

- ▣ Holistic conceptualization
 - ▣ Family Relationships foster recovery
 - ▣ Emotional security
 - ▣ Physical safety
 - ▣ Hope
 - ▣ Cohesion
-

Assessment Considerations

- Individual meetings with child, with family caregivers, and a family session
- Assess for immediate safety concerns
- Assess dyadic relationships within the family
- Detecting abuse
- Identify individual strengths as well as factors within the family, surrounding community, and larger cultural context

National Child Traumatic Stress Network

Current Treatments: TF-CBT

- Trauma-Focused CBT
 - Combines elements from multiple approaches and theories:
 - Cognitive therapy
 - Behavioral therapy
 - **Family therapy**
 - **Attachment theory**
 - Developmental neurobiology
-

Other Interventions

- Group-based intervention
 - Psychoeducation
 - Process Groups
 - Group Therapy
 - Family Therapy
 - Parent-child Cognitive Behavioral Therapy (CPC-CBT)
-

Family Therapy

- Family Systems
 - Attempts to facilitate the development of family features that support ongoing emotional connections.
 - Safety of all
 - Healthier roles for family members
 - Reasonable expectations of one another
 - Open and sensitive discussion of troubling past experiences
 - Balancing individuality and harmony
 - Effective problem-solving
-

“Families Moving Forward”

- Families Moving Forward Intervention
 - Holistic, systems-based treatment for children with Fetal Alcohol Spectrum Disorders (FASD) and their families.
 - Focuses on positive parenting
- Goals can be adapted to when working with families of sexually abused children
 - Support parents
 - Give parents new skills and strategies
 - Enable family members to recognize the signs/symptoms of traumatic stress
 - Encourage family progress in a positive direction
 - Restore hope and optimism to families caring for affected children

Case Vignette

-Mrs. Moreno-

Mrs. Moreno is a 45-year-old, Latina female who has been married for 15 years. She works full-time as an office secretary. She was recently awarded legal guardianship of Audrey (age 10), her foster child of the past 5 years. Mrs. Moreno also has an 18-year-old son who began his first year of college at a local university; he lives on campus and occasionally comes home on weekends. Audrey regularly sees her social worker, approximately once a month, to assess overall functioning and wellbeing since her transition into foster care with Mrs. Moreno. Audrey has recently disclosed to her social worker that she was sexually abused as a child, before she was placed in foster care with Mrs. Moreno. The social worker informs Mrs. Moreno, who reports being aware of the neglect, physical abuse, and poor living conditions Audrey endured. You are now seeing Mrs. Moreno for her first therapy session; she was referred by Audrey's social worker. Mrs. Moreno reports feeling complete shock, sadness, worry, guilt, and hopelessness that she won't be able to “fix” Audrey's past. She reports she has been getting into many arguments with her husband who tells her she takes on too much responsibility and blame for Audrey's traumatic past. Mrs. Moreno reports to you during your first session, that she too was sexually abused as a child and that she has never disclosed this to anyone before.

Clinical Vignette #2

-Mrs. Robertson-

Mrs. Robertson is a 32-year-old, divorced, Caucasian female. She and her ex-husband share custody of their daughter Olivia (age 5). After the divorce, Mrs. Robertson's brother offered her to move in with him, his wife, and their daughter Shane (age 3). Mrs. Robertson has never gone to therapy before and at the initial intake she reports experiencing extreme anxiety, shame, guilt, and confusion for the past month. She is unable to provide an explanation or precipitating factor that may explain the change in her mood. Through the course of your assessment, Mrs. Robertson discloses several new behaviors her daughter exhibits: crying during bath time and covering her naked body, bed wetting, and severe melt-downs when left alone at home (Mrs. Robertson's brother's home). She identifies that her brother babysits Olivia often. When you gently provide education on early warning signs of child sexual abuse and remind her of limits of confidentiality, she curses at you and says there is no way her brother could ever touch Olivia. She threatens to leave the initial intake assessment, however, she begins sobbing and reports feeling a tremendous amount of guilt that she "ruined" her daughter's life, identifies extreme fear she may lose custody of Olivia, and feels "conflicted" over whether she should pursue pressing charges against her brother.

Vignette Reflection Questions

- ▣ What are some of your initial concerns with Mrs. Moreno?
- ▣ What sociocultural considerations seem particularly relevant in this case?
- ▣ Are there any sociopolitical or contextual factors to consider?
- ▣ What are some individual strengths and family strengths?
- ▣ What might be some treatment goals for your work with Mrs. Moreno?

Vignette Reflection Questions

- What are some of your initial concerns with Mrs. Robertson?
 - What sociocultural considerations seem particularly relevant in this case?
 - Are there any sociopolitical or contextual factors to consider?
 - What are some individual strengths and family strengths?
 - What might be some treatment goals for your work with Mrs. Robertson?
-

Closing Comments

- CSA is a nuanced, underrepresented phenomenon and mental health clinicians do not receive adequate training.
 - There are a variety of sociocultural and sociopolitical factors that are associated with child sexual abuse; these factors should be considered as foundational to understanding an individual's and family's experience of CSA and mental health symptoms.
 - Encouraging family progress in a positive direction can restore hope and optimism to families caring for affected children
-



Resources

- Darkness to Light
 - www.d2l.org
 - Education and training, printable family resources, etc.
- The National Child Traumatic Stress Network (NCTSN)
 - www.nctsn.org
 - Printable resources, parent guides, etc.
 - Resources in English, Spanish, Armenian, and Chinese
- Rape, Abuse, and Incest National Network (RAINN)
 - 800-656-HOPE
 - www.rainn.org

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Thank You!

APPENDIX G

Suggested Script for FSAC Webinar

Slide 1:

Welcome to the webinar training for mental health professionals on working with families of sexually abused children.

As a mental health professional, there is a strong likelihood you will come into contact with sexually abused individuals or family members of someone with a sex abuse history. You have a profoundly important role in helping these individuals turn pain and hurt into an opportunity for regrowth and healing, like which is represented in this photo. You can nurture, support, and help individuals during a critical time following trauma and devastation. We hope this introductory training will provide you with insight into the unique challenges families of sexually abused children face and the opportunities clinicians can incorporate into treatment to facilitate posttraumatic family growth and resiliency.

Again, thank you for joining us. The duration of this webinar is approximately 30 minutes. A list of selected resources and references will be listed at the conclusion of the webinar.

Slide 2:

The purpose of this webinar training is to provide a more detailed and in-depth look into child sexual abuse and more specifically, the unique impact on family members of those who have experienced child sexual abuse.

Though this webinar training is considered introductory in nature, the goal is that attendees receive a glimpse into the nuanced need for assessment and treatment of an overlooked sub-population (families of sexually abused children).

This will be achieved by examining important CSA matters including definitions, disclosures, reporting issues, and prevalence rates of CSA.

Additionally, sociocultural and sociopolitical influences as they relate to CSA and family dynamics, will be discussed to increase our understanding as mental health professionals striving for cultural competence and sensitivity with all individuals we treat.

Slide 3:

Additionally, by the end of this webinar, there is the hope that you will have a greater understanding of the treatment needs for families of sexually abused children. We will discuss assessment needs when working with this population, current trauma treatments for families of sexually abused children, and suggested areas of focus for when working with family members. Most importantly, we will identify strengths and resiliency factors among families, and review ways of incorporating these resiliency and sociocultural factors into all aspects of clinical work.

Slide 4:

This webinar was developed as a response to identified gaps in literature, formal education, clinical training, and continuing education for mental health practitioners with regard to child sexual abuse matters.

Currently, training programs appear to address mental health needs and challenges of those who have experienced sexual abuse as a child in a more homogeneous manner, without recognizing some of the important factors that contribute to the variability in experiences and outcomes. That is, the approach to CSA training often neglects to address the unique sociocultural and sociopolitical challenges faced by survivors, perpetrators, and family members of sexually abused children.

More often than not, literature on child sexual abuse focuses more on the psychopathology of trauma, rather than on posttraumatic growth, resiliency, or strength-based factors.

Slide 5:

Another primary reason for developing this webinar was due to the high degree of involvement mental health professionals (MHPs) have in child sexual abuse matters. Due to the lack of specialized training and the high involvement in CSA matters, adequate training is critical.

MHPs are considered “first responders” much in the same way that policemen and paramedics respond to emergencies; mental health professionals have responsibilities relating to advocacy, prevention, screening, detecting disclosure, mandating reporting, and providing intervention. Mental health professionals can play a vital role in reducing the negative effects associated with CSA.

Slide 6:

Mental health professionals are critically influential in decreasing the acute, negative effects of child sexual abuse; they are involved in conducting proper assessment of trauma histories, informing best course of treatment, directing access to resources. MHPs can also increase public interest in CSA, contribute to research, and influence public policy.

Despite being in an opportune position to intervene and assist, many MHPs lack adequate training, resources, support, and are ill equipped to manage the challenges and demands of individuals affected by child sexual abuse. Many doctoral and/or master’s level programs do not offer specialized training for matters of child sexual abuse. Moreover, sup-populations affected by child sexual abuse (such as families of sexually abused children) are often neglected and mental health professionals lack the tools and resources to be of support to these individuals and/or families.

Slide 7:

According to the American Psychological Association, sexual abuse is defined as “unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent” (APA, 2015).

For the purposes of this webinar, we will use the definition provided by RAINN (the Rape, Abuse & Incest National Network), which states “child sexual abuse is a form of child abuse that includes sexual activity with a minor.” Additionally, child sexual abuse does not need to include physical contact between the perpetrator and child.

Some forms of child sexual abuse include: obscene phone calls, text messages, or digital interaction; fondling; exhibitionism, or exposing oneself to a minor; masturbation in the presence

of a minor or forcing the minor to masturbate; intercourse; sex of any kind with a minor, including vaginal, oral, or anal; producing, owning, or sharing pornographic images or movies of children; sex trafficking; and any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare.

Slide 8:

One basic task we must address is identifying the prevalence rates of child sexual abuse. Although CSA is a widespread issue, causing various psychological, emotional, cognitive, social, and behavioral problems, and garnering widespread media coverage and social concern for the welfare of children, difficulties establishing accurate prevalence rates and definitions of child sexual abuse continue to persist.

The variation in prevalence rates largely depends on the definition of sexual abuse being used, population sampled, data collection methods, response rates, as well as other methodological and cultural factors.

With a more thorough understanding of inconsistencies in prevalence rates and reporting of CSA, we will begin to gain insight into the underlying and widespread issues related to CSA at the micro and macro levels.

Some of the variability in prevalence may also be due to the lack of a consistent definition of child sexual abuse. Definitions vary based on the inconsistent criteria of whether physical contact is required, maximum age of the victim, minimum age of the perpetrator, minimum age difference between the victim and perpetrator, and whether only unwanted experiences are considered.

Research has also introduced the notion of cultural differences of child sexual abuse definitions, adding to the complexity of defining, disclosing, reporting, and adequately capturing the phenomenon of childhood sexual abuse in the United States. Whilst no significant differences have been found defining child sexual abuse amongst white Americans, African Americans, and Hispanic Americans (Lowe Jr., Pavkov, Casanova, & Wetchler, 2007), it is a noteworthy consideration to understand the lack of a singular definition of child sexual abuse that is consistent across cultures.

In addition, “sexual” within the context of sexual abuse, may take on a rigid definition of requiring physical contact, when many studies include non-contact experiences under the umbrella of CSA, including voyeurism, exposure, and child pornography.

Slide 9:

Child sexual abuse is disclosed or revealed in a myriad of ways; only one of which is direct disclosure by child victims to an adult when seeking protection or help. CSA is often discovered through other routes; it rarely comes to light from a child's self-report.

CSA is often revealed through other methods such as dropping hints to parents, teachers, or community leaders; parents or adults witnessing “suspicious” behavior; accidental reporting of suspicious behavior from children; signs of physical trauma; unexplained somatic complaints; journaling and/or diary keeping; soiled or stained clothing discovered by family members; and

emergency room discovery of genital wounds, pregnancy, or sexually transmitted disease (STD) (Fontes, 2010).

In other cases, mothers' subjective feelings that 'something was amiss' was translated into mothers taking action in an attempt to make sense of vague suspicions (Malloy et. al, 2011).

Slide 10:

"Grooming" behaviors also contribute to delayed disclosure of CSA. Children may become accustomed to an escalating set of events that progress from innocent to more serious abuse incidents. Children may not have the language or cognitive abilities to comprehend what abuse has happened, or the perpetrator may have purposely provoked confusion, such as alluding to the incidents as a "dream" or "nightmare" not based in reality. Children are also frequently threatened to keep incidents of CSA private. In one study, 46% of males (compared to 71% of females) disclosed their abuse, suggesting that male survivors delay disclosure well into adulthood. Men are reluctant to disclose sexual abuse, due to fears of being labeled as homosexual or deviant, which may partially explain the considerably underreported instances of sexual abuse for men (Easton, 2013; Hunter, 2006) Age may also be correlated to delayed disclosure. Specifically, young age at time of first abuse experience tends to correlate with non-disclosure, longer delays in disclosure, and non- intentional disclosure (Sjöberg & Lindblad, 2002). Due to these and additional internal and external factors influencing disclosure, as well as the fact that many child sexual abuse incidents are never disclosed, it can be said that the prevalence rates of child sexual abuse are largely under-represented.

Slide 11:

Literature reveals that families in which sexual abuse has occurred tend to be less cohesive (have less emotional bonding), have more problems coping with stress and adapting, are more socially isolated, are more controlling, exhibit poor communication and high conflict and display rigid traditional family values (Alaggia & Kirshenbaum, 2005).

Other studies cite high levels of conflict, marital discord, family violence, substance abuse, and disconnection from social supports as correlates found relevant to perpetrators and/or victims of abuse.

Insecure personal attachment in a family may also increase the risk of child sexual abuse within the family.

These risk factors share a few common threads: weak attachment of parents to their children or where parents/caregiver exert poor impulse control and/or risky behaviors may be associated with higher risk for child sexual abuse. To frame things from a more positive perspective, it appears that family cohesion, secure attachments, and families with adequate supports may serve as protective factors against CSA or possibly earlier disclosure of CSA. Families in which there is trust, open communication and adaptive coping styles appear to bring families closer together where problems are identified and there are adequate emotional resources available in the parent/caregiver to attend to identified problems.

Slide 12:

Hypotheses related to IFCSA propose that offending fathers or step-fathers are likely to take on an authoritarian, patriarchal role; the marital relationship is aloof and characterized as low in sexual intimacy and/or high in conflict; mothers are more likely to be dependent on the father, financially or otherwise; some daughters are pushed into a surrogate partner role, not only sexually but also with regard to intimacy and household tasks, such as supervision and care of younger children (Seto et al., 2015).

Clinicians or investigators have suggested that patriarchal attitudes and beliefs, emotional congruence with children, childhood difficulties with sexual abuse, poor attachment to parents, interpersonal deficits, and psychopathology are important factors in explaining IFCSA. The common theme across the first four explanations is that intrafamilial offenders turn to children to meet their sexual or emotional needs, possibly because for some, they themselves were victims of incest. The common theme across the next two explanations is that intrafamilial offenders are less able to pursue sexual opportunities outside the family due to interpersonal deficits or psychopathology and hence, they 'keep it in the family,' because they do not have the opportunity to offend against unrelated victims.

Instances of intrafamilial child sexual abuse can often go underreported due to the sheer power imbalance within controlling patriarchal communities. Further, children who have been victimized by family members may choose to not disclose instances of sexual abuse due to foreseeable shame to the family, which is a crucial factor to cohesion and harmony in various communities.

Slide 13:

Other considerations that may influence delayed disclosure of CSA involve sociocultural and sociopolitical factors. Certain issues that present differently and are weighted heavily in various cultures may silence disclosures of CSA.

First, lower prevalence rates of CSA among ethnic minority groups are more attributed to barriers of disclosure, rather than a genuine and substantially higher prevalence rate among Anglo populations.

Family dynamics can play a significant role in underreporting and ultimately, inaccurate prevalence rates. Sociocultural issues are relevant to CSA matters due to overt gender inequalities and culturally-informed beliefs. These themes often relate to shame, taboos and modesty, sexual scripts, virginity, women's status, obligatory violence, honor, respect, and patriarchy.

Sexual abuse allegations against fathers or other senior males may be regarded as attacks against an entire family. Thus, in order to save the reputation of one's family, it is often the accuser and/or victim that is excluded by the family rather than the alleged abuser.

Another sociopolitical factor influencing reporting issues is the notion that in many cultures and communities, children are deemed powerless. By nature of this dependent relationship dynamic and power differential between child and parent, children are in a more vulnerable position to be abused. This, in addition to the gender discrimination, contributes to a variety of sociopolitical and sociocultural barriers for those affected by child sexual abuse.

Slide 14:

Understanding the values that are often held by individuals and within various cultural groups can enhance our ability to detect nuanced factors affecting CSA disclosure among different cultural groups.

Still, it remains crucial to point out that although conceptualizing collectivistic and individualistic frameworks may be helpful, it is equally important to not allow these frameworks to define an individual's experience. Thus, macro-level conceptualizations of culture should be combined with nuanced understandings of culture as it pertains specifically to an individual or family.

Slide 15:

While this is not an exhaustive list, cultural values relating to shame, taboo, modesty, sexual scripts, virginity, status of women, honor, respect, and patriarchy can have a powerful influence on how instances of CSA transgress.

Children may choose to not disclose instances of sexual abuse due to bringing foreseeable shame to the family, which is a crucial factor that effects cohesion and harmony in various communities.

One study suggests that sexual abuse has the lowest prevalence rates within Asian cultures compared to other races and ethnicities. Choi, Choo, Choi and Woo (2015) They explain that disclosure of sexual abuse would likely bring family embarrassment, loss of family status, disharmony; a child's powerlessness and deference to elders would likely contribute to secrecy, underreporting, silence, lack of resources and unwillingness to obtain treatment (Choi, Choo, Choi & Woo, 2015). This is but one example of how sexual abuse concepts must be considered among an individual's local, social world, inclusive of sociocultural and sociopolitical systems. With regard to taboos and modesty, environments where discussions of sexuality is taboo can make it more difficult for children to disclose CSA. Values of *haya* (modesty) and *sharam* (shame/embarrassment) in Arab cultures and *pudor* (shame, modesty) in Latinx cultures with accompanying phrases like *de eso no se habla* ("that is not spoken of") that are reactions from Latinx parents, contribute to secrecy, shame, and underreporting (Fontes, 2007).

There are beliefs that boys and men cannot control themselves when it comes to sex; girls and women have to "keep their legs closed and hide their bodies." Girls abused within cultures that teach these scripts may blame the female for "tempting" a man or dressing provocatively that may or may not precipitate CSA. Boys or men in question are not blamed due to attitudes that "boys will be boys." These scripts also affect boys' disclosure of CSA as it would imply that they are less manly for not wanting sexual activity with an older female. Disclosure of CSA where the perpetrator and victim are both male can bring about highly stigmatized disclosures of CSA due to impacted masculinity and suspicion of homosexuality.

In cases where penetration did not occur, female value isn't solely contingent in virginity, but on her "honor" or reputation. These notions inhibit disclosure of sexual assaults throughout the world.

Honor, Respect & Patriarchy- South Asian communities may inhibit children from disclosing incidents of CSA due to strong values of *izzat* (honor/respect), filial piety in East Asian cultures, or *respeto* (respect) in Latinx cultures.

Religious Values- religious norms and expectations may make disclosure of CSA difficult.

- E.g., Catholic women may be expected to suffer abuse in silence, with abuse being a phase they have to bear. Spanish term of *aguantarse* or *sobreponerse*, meaning to endure or resign oneself. Belief in an omnipotent Father or God may translate into the belief that a male clergy member perpetrating abuse also has similar rights to do as he pleases.

- Buddhist belief that abuse is karma for a misdeed in a previous life; victims or families of victims may be told to not proceed with prosecutions of CSA to end cycle of negative karma.

- Jewish values of honoring one's parents can predispose children to limit disclosures of abuse. *Lashon Hara*, prohibition against speaking ill of others, can be used to justify why perpetrators are not publicly identified (Fontes & Plummer, 2010).

Additionally, children, by nature and definition, are powerless and reliant on adults and caretakers for getting basic needs met as well as ensuring their safety and survival. By nature of this dependent relationship dynamic and power differential, children are in a more vulnerable position to be abused.

Slide 16:

Cultural factors are not wholly negative when it comes to CSA disclosure. Cultural factors may make it difficult for children to disclose or family members to proceed with prosecution; however, cultural factors may also facilitate disclosures.

Strong mother-child relationships lead to more disclosure and fewer recantations

Other cultural protective factors include: intolerance of adult sexual practices with children, high value placed on women and children, extended family supervision of children, men's direct involvement in raising children, close relationships, social sanctions against abuse, open discussions of sexuality, and other informal resources

Slide 17:

In addition to sociocultural factors including values and beliefs that may influence disclosures of CSA, there are also sociopolitical factors to consider. These include safety, poverty, community resources, legal action, risk of having children taken into CPS custody.

Threats of violence from a perpetrator of CSA may impact disclosure and prosecution.

Potential legal costs, childcare costs and other financial stressors that families face when facing CSA related procedures, including prosecution, can influence disclosure rates. Community resources related to CSA, including education, advocacy, and treatment, may be significantly lower in areas that are financially strained.

Slide 18:

The impact of trauma is wide reaching whether the CSA occurred within the family (intrafamilial) or whether the perpetrator was a non family member.

For intrafamilial abuse, this experience can be extremely confusing for a child. Adult figures are initially interpreted to be "safe" persons who the child trusts instinctually.

The effects of CSA on non-offending parents and/or caregivers is overlooked in the literature. While they may have been aware of the ongoing abuse, they may have had their safety threatened and/or they may have been concurrently abused (i.e., sexually, physically, emotionally, etc.)

Slide 19:

Stress contagion is a commonly used term to describe the emotional phenomena of how others viewing or hearing of other's stressful and or traumatic experiences can create a "contagious" physiological response in the observer. The effects of any traumatic event reverberate throughout the family system. A child's greatest need for love and support may come at a time when the trauma itself has compromised a family's ability to provide it.

Parents in the throes of traumatic stress reactions may question their ability to adequately parent their children and to maintain family routines and roles.

Parental withdrawal, overprotectiveness, excessive preoccupation with the trauma, ongoing anxiety and depression, or PTSD symptoms can directly or indirectly exacerbate a child's traumatic stress symptoms.

The emotional and cognitive responses of self-doubt, shame, guilt, withdrawal can co-exist or lead to the onset of psychiatric symptoms such as anxiety and/or depression. Other responses include decreased self-efficacy, self blame, betrayal, helplessness, hopelessness, and concern about the investigatory and judicial process.

To get us thinking about what this may look like in a family, imagine you are meeting with Desiree, the mother of a 12-year-old child who has recently disclosed being abused by a family friend. Her son, David, once energetic and talkative, now barely eats and rarely talks to his other brothers and sisters. He has been receiving individual therapy from another clinician; after he had been in treatment for a month, you received a referral request to see his mother. When you meet with Desiree for the first time, she reports that before this incident she had the usual stresses related to work, meeting deadlines, paying bills, and caring for her 3 children. She states that now after her child's CSA disclosure, she can't focus, is performing poorly at work, doesn't sleep, feels generalized pain and GI-related problems, and can't seem to get her mind off of worrying about the welfare of her children. Some of these symptoms and concerns can be thought of as a stress-contagion response because of the almost immediate onset following the child's disclosure and presentation of stress and mental health concerns.

Slide 20:

Identifying individualized and holistic conceptualizations for the family unit will be essential to engaging coping resources to support the child the family unit move forward towards growth and resiliency.

Focusing on family relationships post CSA disclosure is indispensable to the traumatized person's recovery, as family relationships and bonds simultaneously provide essential support for the restoration of emotional security, physical safety, and hope. Children in families that are cohesive, caring, and emotionally involved are more likely to recover from the effects of trauma.

Slide 21:

Important considerations when working with FSAC include astute assessment, including sociocultural and sociopolitical considerations when conceptualizing, treatment planning, and implementing interventions. Astute assessment skills will also aid when detecting abuse. A trauma-specific, family centered assessment can provide valuable feedback to the family and clinician so that treatment can adequately target the specific and interrelated needs of children and their families.

Best practices in family assessment include having an individual meeting with the child, and individual meeting with primary caregivers, and a family session. The family session should include everyone in the household. By doing this, you will learn which members may provide the most support to the child, which family members are open to mental health treatment, and any symptoms or behaviors that cause concern. Additionally, an important step is understanding and addressing any immediate safety concerns the family may be facing.

Further, an assessment of each dyadic relationship within the family may provide insightful information of the various family interactions. Consider how parents interact with one another; how each parent interacts with each child; and how siblings interact with one another. Multiple data sources helps you obtain a fuller, more complete picture of the family's functioning. This kind of assessment enables you to assess family resources and assets, as well relationships within the family system that need special attention.

If you are providing family-based treatment for reasons other than trauma, you may come into contact with children who have not yet disclosed trauma or abuse. For this reason, therapists and counselors also need to cultivate the necessary skills to pick up on subtle cues and difficult-to-discern patterns of behavior.

Overall, ethical family assessment is a vital opportunity for a mental health clinician to gain insight into strengths of individuals, families, and the community, in order to bolster coping and growth.

Slide 22:

TF-CBT is an evidence-based treatment that helps children address the negative effects of trauma, including processing their traumatic memories, overcoming problematic thoughts and behaviors, and developing effective coping and interpersonal skills. It also includes a treatment component for non-offending parents or other caregivers. Parents can learn skills related to stress management, positive parenting, behavior management, and effective communication.

TF-CBT combines elements drawn from multiple approaches and theories:

- Cognitive therapy, which aims to change behavior by addressing a person's thoughts or perceptions, particularly those thinking patterns that create distorted or unhelpful views.
- Behavioral therapy, which focuses on modifying habitual responses (e.g., anger, fear) to non-dangerous situations or stimuli
- Family therapy, which examines patterns of interactions among family members to identify and alleviate problems
- Attachment theory, which emphasizes the importance of the parent-child relationship, particularly issues of trust and security

-Developmental neurobiology, which provides insight into the child's developing brain
(Child Welfare Information Gateway)

The elements of family therapy and attachment theory are particularly salient to this training. Within TF-CBT, non-offending parents or caregivers are included in treatment. A family therapy approach looks at interactions among family members and other family dynamics that may be contributing to or maintaining the identified problems. An important element of therapy aims to provide psychoeducation to both the child and parent, and aims to teach new parenting, stress-management, and communication skills. From attachment theory, TF-CBT aims to re-engage and strengthen the enduring emotional bond between parent and child. Emotional bonds with others (attachments) are what help connect others through time and space, which can increase a sense of safety, security, and improve emotional regulation skills.

Slide 23:

A family systems approach aims to change individual family members and restructure, rebuild, and restore healthy family relationships. This model attempts to facilitate the development of emotionally supportive family dynamics which include: safety of all; healthier roles for family members; reasonable expectations of one another; open and sensitive discussion of troubling past experiences (in place of keeping secrets from one another or other forms of avoidance in dealing with the past); balancing individuality and harmony; and effective problem solving.

Slide 24:

There are a variety of methods to implement interventions. Whatever model you may be operating from, conceptualization that includes sociocultural factors and utilizing these to draw upon strengths embedded into the individual, their family, community, and larger social world is ethical and effective.

Psychoeducational groups can help educate family members about trauma symptoms, reactions to trauma; healthy relationships; parent education; stress management; and promoting well-being.

Process groups geared to parents can be helpful, especially for families of collectivistic cultures. They may benefit from a group-based approach where they are with other children their age, and other parents in similar situations. This can reduce a sense of shame and isolation, and can help individuals learn and bolster use of helpful coping strategies.

Benefits of group therapy for families of sexually abused children include: education, dissemination of trauma related phenomena, peer role modeling, coaching in skills for understanding and communicating effectively with children and peers. Yalom's 11 therapeutic factors in group therapy may be especially helpful for families of sexually abused children. These factors are: universality, altruism, instillation of hope, guidance, imparting information, developing social skills, interpersonal learning, cohesion, catharsis, existential factors, imitative behavior, and corrective recapitulation of family of origin issues.

Family therapy helps to restore relationships between all members, including but not limited to, relationships with the traumatized member. It can offer information and support to a family, which can lead to increased levels of recovery and functioning of the entire family.

Parent-Child Cognitive Behavioral Therapy (CPC-CBT) is an evidence based model that empowers families and has been shown to reduce parental use of corporal punishment, enhance positive parenting skills, and reduce children's trauma symptoms.

Slide 25:

"Families Moving Forward" is an intervention program that focuses on helping children with fetal alcohol spectrum disorders (FASD), their families, and the professionals who care for them. Parents and other support people work hard to find services to meet the complex needs of children and adults with FASD. Unfortunately, people with FASD do not easily qualify for services offered in the schools and community. Providers have limited training in FASD and don't always know the best way to help and support people with FASD. Few specialized services exist for people with FASD and their families.

While the protocol is meant for a different clinical presentation, the overarching goals are applicable to working with families of sexually abused children. Parents or caregivers of those with FASD appear to face similar difficulties of families of sexually abused children: limited knowledge about their child's illness (FASD) or emotional pain (CSA): limited resources or specialized services exist for people who have FASD or families with children who have experienced CSA. Thus, much of the content incorporated into Families Moving Forward appear applicable to families of sexually abused children.

Applicable content includes the following goals:

- Support parents and help them better understand their affected children
- Give parents new skills and strategies to use when caring for their children
- Enable teachers and health care providers, as well as family members, recognize the signs/symptoms
- Encourage family progress in a positive direction

Restore hope and optimism to families caring for affected children

Using this intervention program as a model framework, families of children with FASD and families of sexually abused children and can both learn about their child's illness, increase their parenting skillset, receive positive support from a community that understands their struggles, and bolster hope for themselves, their families, and their children.

Slide 26:

We're now going to practice reviewing what we've learned by studying a case vignette.

Slide 27:

Some initial questions are written here on the slide. Take a few moments and jot down your thoughts about these questions. You can put the webinar recording on pause while you do this. Now, let's discuss the questions. I will share some things that are important to consider. You may have thought of others and that is great!

1.) What are some of your initial concerns with Mrs. Moreno?

-Consider crisis issues: is Mrs. Moreno so depressed, worried, or hopeless that she may be contemplating hurting herself?

-Is Audrey in crisis?

-Safety: what is Mrs. Moreno's relationship with her husband? Is he physically, emotionally, or verbally abusive towards Mrs. Moreno? Towards Audrey?

-What is Mrs. Moreno's relationship like with Audrey? What style of communication do they use?

-Any history of substance use/abuse that may be triggered by disclosure of CSA?

2.) What sociocultural considerations seem particularly relevant in this case?

-What was Mrs. Moreno's family environment like during her upbringing?

-She identifies as Latinx; how is CSA viewed in her culture, religion, in her local social world?

-How does she and the larger cultural context view mental illness?

-What cultural beliefs and/or values related to women and children are relevant in this case?

-Because Mrs. Moreno identified a personal history of sexual abuse victimization, what cultural values related to sexuality, modesty, or virginity are worth exploring that may be contributing to her presentation?

-How does Mrs. Moreno/her culture view and experience sadness, anxiety, guilt, and shame?

3.) Are there any sociopolitical factors to consider?

-Broken child welfare systems, foster care system

-How long was the child in the foster care system before she was placed with Mrs. Moreno?

-What are Mrs. Moreno's reasons for wanting to foster children, and how might these reasons be affecting her current situation?

-What is the community like? Impoverished? Wealthy? Is there substantial access to resources and/or education?

-Does Mrs. Moreno have affiliations or ties to the community? Is she a community leader?

4.) What are some individual and family strengths?:

-Mrs. Moreno is receptive to getting help and improving her situation

-Cares deeply for others

Questions to consider:

-How does Mrs. Moreno handle stress and challenges?

-How does the family unit deal with problems?

-What is their communication style?

5.) Treatment Goals:

-Receive education related to child sexual abuse.

-Learn about trauma-related symptoms, and receive accurate info about trauma exposure and recovery.

-Identify cultural specific beliefs about trauma, beliefs about mental health treatment, and culturally specific beliefs related to healing and personal growth.

-Help client develop enhanced skills designed for parenting a traumatized child.

-Identify culturally sensitive and culturally syntononic ways of expressing emotion and identifying ways of regulating distressing emotions.

-Identify individual supports, supports within the family unit, and supports from the larger community and culture, that can be helpful in providing relief to Mrs. Moreno.

Slide 28:

Let's see a second vignette.

Slide 29:

Some initial questions are written here on the slide. Take a few moments and jot down your thoughts about these questions. You can put the webinar recording on pause while you do this. Now, let's discuss the questions. I will share some things that are important to consider. You may have thought of others and that is great!

1.) What are some of your initial concerns with Mrs. Robertson?

- Mandated reporting; for Olivia and Mrs. Robertson's niece, Shane.
- Ensure children's safety; avoid having Olivia (and Shane) at home alone without Mrs. Robertson's supervision.
- Provide resources for CSA support (National Sexual Assault Hotline 800 656 HOPE)
- Consider crisis issues: is Mrs. Robertson at increased risk for suicide or self-injurious behavior?
- What is Mrs. Robertson's relationship like with Olivia? What style of communication do they use? Attachment style?
- What is her communication style and relationship with her brother?

2.) What sociocultural considerations seem particularly relevant in this case?

- What was Mrs. Robertson's family constellation/ family environment like during her upbringing?
- How is CSA viewed in her culture, religion, community, in her local social world?
- What cultural beliefs and/or values related to patriarchy, women's status/power, and children are relevant in this case?
- What cultural values related to sexuality, modesty, or virginity are worth exploring that may be contributing to her presentation?
- How does Mrs. Robertson/her culture view and experience sadness, anxiety, guilt, and shame?

3.) Are there any sociopolitical factors to consider?

- Shared custody with ex-husband. How will the larger legal/justice system see this situation?
- How is her relationship with the ex-husband?
- Does she anticipate a certain reaction (punitive/supportive) from her ex-husband?
- Socioeconomic factors: how does being a recently divorced, single mother affect her current presentation?
- Fees/finances required for pursuing legal adjudication against her brother
- Does Mrs. Robertson have adequate housing options if she can no longer live with her brother, the alleged perpetrator?
- What is the community like? Impoverished? Wealthy? Is there substantial access to resources and/or education and support?
- Does Mrs. Robertson have affiliations or ties to the community?

4.) What are some individual and family strengths?:

- Mrs. Robertson is receptive to getting help and improving her situation
- Cares deeply for her child's safety and wellbeing
- What is Mrs. Robertson's relationship with her sister-in-law (alleged perpetrator's wife)?
- Other supportive family members or trusted friends?

Questions to consider:

- How does Mrs. Robertson typically handle stress and challenges?
- How did her family unit adaptively deal with problems?

5.) Treatment Goals:

- Receive education related to child sexual abuse.
- Learn about trauma-related symptoms, and receive accurate info about trauma exposure and recovery.
- Identify cultural specific beliefs about trauma, parenting, sexual abuse, seeking mental health treatment, and culturally specific beliefs related to healing and personal growth.
- Help Mrs. Robertson process feelings of guilt and self-blame
- Help Mrs. Robertson develop enhanced skills designed for parenting a traumatized child.
- Help Mrs. Robertson identify culturally sensitive and culturally syntononic ways of expressing emotion and identifying ways of regulating distressing emotions.
- Identify individual supports, supports within the family unit, and supports from the larger community and culture, that can be helpful in providing relief to Mrs. Robertson.

Slide 30:

We are now approaching the end of the webinar. Some closing statements are here for your review.

Slide 31:

Now that the webinar has come to a close, we'd like to open up the floor to any participant questions.

Slide 32:

Darkness to light is a great online resource. There are selected guides and resources on reporting CSA, talking to kids about digital safety, being the trusted adult, etc.

RAINN is the nation's largest anti-sexual violence organization. They have online resources in English and Spanish related to helping survivors, educating the public, improving public policy, and consulting & training.

NTSC has plenty of resources and printable information sheets (in English, Spanish, Armenian and Chinese) on how to identify child sexual abuse, what to do if your child discloses, coping with the shock of intrafamilial child sexual abuse, etc.

Slide 33:

References

Slide 34:

Thank you for attending this webinar. Please feel free to send questions or comments to [enter email address.]

APPENDIX H

IRB Approval Letter



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: May 11, 2018

Protocol Investigator Name: Adriana Janicic

Protocol #: 17-10-647

Project Title: Development of an Introductory Webinar Training on Child Sexual Abuse and Exploitation of Youth: A Strengths-Based Sociocultural Perspective.

School: Graduate School of Education and Psychology

Dear Janicic:

Thank you for submitting your amended expedited application to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today May 11, 2018, and expires on April 15, 2019.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond April 15, 2019, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the **Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual** at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

scholarly pursuit.

Sincerely,

Judy Ho, IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist